ForwardHealth
Wisconsin serving you

Update
June 2009

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Affected Programs: BadgerCare Plus, Wisconsin Chronic Disease Program
To: Ambulatory Surgery Centers, Blood Banks, Dentists, Dispensing Physicians, End-Stage Renal Disease Service Providers, Family Planning Clinics, Federally Qualified Health Centers, Home Health Agencies, Hospital Providers, Nurse Midwives, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

BadgerCare Plus Core Plan for Adults with No Dependent Children-Covered Pharmacy Services

Beginning on June 15, 2009, the BadgerCare Plus Core Plan for Adults with No Dependent Children will begin accepting applications for enrollment from the general public as part of the second phase of Core Plan implementation. Coverage for qualified individuals who apply during the second phase of Core Plan implementation will begin on July 15, 2009.

This *ForwardHealth Update* describes covered pharmacy services for newly enrolled Core Plan members and Core Plan members who transitioned from the Milwaukee County General Medical Assistance Program and other counties' general assistance medical programs.

Overview of BadgerCare Plus Core Plan Implementation

On January 1, 2009, the Department of Health Services introduced the BadgerCare Plus Core Plan for Adults with No Dependent Children, also known as the BadgerCare Plus Core Plan for Childless Adults, as part of Wisconsin's comprehensive health care reform. The Core Plan provides adults who previously were not eligible to enroll in state and federal health programs such as BadgerCare Plus with access to basic health care services including primary care, preventive care, certain generic and over-the-counter (OTC) drugs, and a limited number of brand name drugs.

First Phase

In the first phase of Core Plan implementation, individuals enrolled in the Milwaukee General Assistance Medical Program (GAMP) and certain other counties' general assistance (GA) medical programs were automatically transitioned into the Core Plan effective January 1, 2009. Services were covered under fee-for-service. Effective April 1, 2009, members transitioned from GAMP began their enrollment process in one of the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population.

Second Phase

In the second phase, BadgerCare Plus will begin accepting applications from the general public for enrollment in the Core Plan as of June 15, 2009. The second phase opens enrollment to certain low-income adults with no dependent children. The earliest date of coverage and benefits will be July 15, 2009. Services will be covered under fee-for-service until members are enrolled in an HMO. All new Core Plan members will be required to enroll in an HMO under the following circumstances: there are two or more HMOs in the member's area, or there is one HMO in the member's area and the member resides in a designated rural county where federal requirements allow mandatory HMO enrollment. New Core Plan members will receive HMO

enrollment materials in the mail to select an HMO. The earliest date of HMO enrollment for new Core Plan members will be October 1, 2009.

Covered Pharmacy Services for Core Plan Members

The Core Plan has a closed drug formulary. Certain generic and OTC drugs and a limited number of brand name drugs were covered for the Core Plan for transitioned members effective for dates of service (DOS) on and after January 1, 2009. Effective for DOS on and after July 1, 2009, ForwardHealth will expand the list of covered drugs to include brand name drugs in specific drug classes for newly enrolled *and* transitioned Core Plan members. Refer to the Core Plan Quick Reference on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for a list of specific drug classes for which brand name drugs will be covered for newly enrolled and transitioned members.

Provider-administered drugs are reimbursed by BadgerCare Plus fee-for-service.

Family planning services, including oral contraceptives, may be covered for Core Plan members enrolled in the Family Planning Waiver.

For a complete list of generic and OTC drugs covered by the Core Plan, providers may access the regularly revised BadgerCare Plus Core Plan National Drug Code List on the Portal beginning in June 2009. The Core Plan Brand Name Drug Quick Reference, which includes the Core Plan formulary, is available on the Portal and on the ePocrates Web site at *www.epocrates.com/*. Providers may also refer to the Drug Search Tool on the Portal to search for specific drugs covered by the Core Plan.
The Pharmaceutical Care dispensing fee and the repackaging allowance are covered by the Core Plan.

Diagnosis-Restricted Drugs

Drugs used for treatment outside approved diagnoses are considered noncovered services. Providers will receive Explanation of Benefits (EOB) code 1556, with a message stating, "This National Drug Code is not covered under the Core Plan for the diagnosis submitted," on claims submitted with diagnosis codes outside approved diagnoses. Claims for diagnosis-restricted drugs submitted for use outside approved diagnoses may be submitted to BadgerRx Gold.

Providers should not submit a prior authorization (PA) request for a diagnosis-restricted drug for use outside approved diagnoses. Prior authorization requests for drugs with a diagnosis outside approved diagnoses will be returned to the provider with a message stating, "The services requested are not covered under the BadgerCare Plus Core Plan. Providers are reminded that they must adhere to the service limitations specified by the BadgerCare Plus Core Plan."

For diagnosis-restricted drugs, allowable diagnoses for the Core Plan are the same as the BadgerCare Plus Standard Plan, with the exception of diagnoses for Provigil, Suboxone, and Subutex.

Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page on the Portal for a list of approved diagnoses.

Quantity Limits

ForwardHealth has established quantity limits for Provigil, Suboxone, and Subutex.

ForwardHealth allows a maximum of 200 mg per day of Provigil and 32 mg per day of Suboxone or Subutex. To adhere to established quantity limits, members may be dispensed two 100 mg tablets per day or one 200 mg tablet per day of Provigil. For Suboxone and Subutex, members may be dispensed any combination of two- or eight-milligram tablets, not to exceed the 32-mg dose per day limit.
Any dose that exceeds the quantity limits previously described is a noncovered service.

Providers may refer to the Quantity Limits data table on the Pharmacy page of the Portal for more information about quantity limits.

Prior Authorization

With one exception for transitioned members, the following are the only drugs for which PA is required for all Core Plan members:

- Byetta and Symlin.
- Cytokine and cell adhesion molecule (CAM) antagonist drugs.
- Provigil.
- Suboxone and Subutex.

Prior authorization requests submitted for drugs that do not require PA will be returned to the provider.

If a drug requires PA and a valid PA is not obtained, claims will be denied with EOB code 1555, with a message stating, "A valid Prior Authorization is required. Follow specific Core Plan policy for PA submission."

Core Plan members do not have appeal rights if a PA request for a drug is denied or approved with modifications by ForwardHealth. Claims for drugs for which PA requests have been denied may be submitted to BadgerRx Gold.

New Prior Authorization Drug Attachment Forms

The following Prior Authorization Drug Attachment forms for Core Plan members have been developed by ForwardHealth:

- Prior Authorization Drug Attachment for Byetta and Symlin, F-00080 (06/09).
- Prior Authorization Drug Attachment for Provigil, F-00079 (06/09).
- Prior Authorization Drug Attachment for Suboxone and Subutex, F-00081 (06/09).

Prescribers should complete the appropriate Prior Authorization Drug Attachment and submit it to the pharmacy provider where the prescription will be filled.

Refer to Attachments 1 through 6 of this *Update* for the completion instructions and forms.

Prior Authorization/Preferred Drug List Forms

Prescribers are required to complete one of the following existing Prior Authorization/Preferred Drug List (PA/PDL) for cytokine and cell adhesion molecule antagonist (CAM) drugs forms and submit it to the pharmacy provider where the prescription will be filled:

- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304 (10/08).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305 (10/08).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306 (10/08).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307 (10/08).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis, F-11308 (10/08).

Prescribers may refer to the Forms page of the Portal for these PA/PDL forms.

Submitting Prior Authorization Requests

Providers are required to complete and submit the following information to ForwardHealth with each PA request:

- A Prior Authorization Request Form (PA/RF), F-11018 (10/08), completed by the pharmacy provider.
- The appropriate Prior Authorization Drug Attachment or PA/PDL form completed by the prescriber.

- Additional supporting clinical documentation from the prescriber.

Prior authorization requests may be submitted on the Portal, by fax at (608) 221-0885, or by mail to the following address:

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

Providers cannot submit PA requests through the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system for Core Plan members.

Certain PA requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, a physician's prescription, clinical reports, and other materials related to the member's condition.

Clinical Criteria Requirements

Prescribers are required to provide clinical information on PA forms so pharmacy providers can submit PA requests to ForwardHealth.

Clinical Criteria for Byetta and Symlin

Criteria for approval of a PA request for Byetta are the following:

- The member has Type II diabetes.
- The member is at least 18 years of age.
- The member is taking a sulfonylurea, metformin, or thiazolidinedione.
- The member has failed to achieve adequate glycemic control despite using a maximum dose of a sulfonylurea, metformin, or a thiazolidinedione. (*Note:* If a member is unable to tolerate a maximum dose of a sulfonylurea, metformin, or thiazolidinedione, he or she must try to obtain adequate glycemic control or maximum dosing on a drug in each of the remaining drug categories.)
- The member is not using the drug for weight loss.

Criteria for approval of a PA request for Symlin are the following:

- The member has Type I or Type II diabetes.
- The member is at least 15 years of age.
- The member is currently taking insulin and failed to achieve adequate glycemic control despite optimal insulin management, including the use of meal time insulin.
- The member's glycated hemoglobin (HbA1c) is less than nine percent.
- The member has not obtained emergency treatment for severe hypoglycemia two or more times in the past six months.
- The member does not have gastroparesis.
- The member does not have hypoglycemia unawareness.
- The member is not using the drug for weight loss.

Clinical Criteria for Provigil

Criteria for approval of a PA request for Provigil are the following:

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- For members with a diagnosis of narcolepsy:
  - ✓ A polysomnogram (PSG) has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - ✓ A multiple sleep latency test (MSLT) has been performed for the member. (*Note:* Test results for the MSLT must be submitted with the PA request.)
- For members with a diagnosis of obstructive sleep apnea/hypopnea syndrome:
  - ✓ The member has tried a continuous positive airway pressure (CPAP) machine.

- ✓ A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
- ✓ The member's apnea-hypopnea index measures over five events per hour.

- For members with a diagnosis of shift work sleep disorder:
  - ✓ The member is a night shift worker.
  - ✓ The member is not currently taking hypnotics, sleep aids, or drugs that cause sleepiness.
- For members with a diagnosis of attention deficit disorder or attention deficit hyperactivity disorder:
  - ✓ The member has a history of substance abuse/misuse or a serious risk of drug diversion.
  - ✓ The member has tried and failed Strattera or the member had a clinically significant adverse reaction to Strattera.

Clinical Criteria for Suboxone and Subutex

Criteria for approval of a PA request for Suboxone and Subutex are the following:

- The member is at least 16 years of age.
- The member has a diagnosis of opioid dependence.
- If the member is female, she cannot be nursing.
- The drug is being prescribed by a physician who has obtained a Drug Addiction Treatment Act (DATA 2000) waiver.
- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.

For Subutex, the member must be pregnant or the member must have a documented allergy to naloxone.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Drugs

Criteria for approval of a PA request for cytokine and CAM antagonist drugs for Core Plan members are the same as the clinical criteria requirements for the Standard Plan. Providers may refer to the Online Handbook for clinical criteria requirements for cytokine and CAM antagonist drugs.

BadgerRx Gold

All Core Plan members will be automatically enrolled in BadgerRx Gold. Providers should submit claims to BadgerRx Gold for drugs that are not covered by the Core Plan.

BadgerCare Plus does *not* coordinate benefits with BadgerRx Gold for members enrolled in the Core Plan.

Claims submitted to the Core Plan for noncovered drugs will be returned to providers with EOB code 0237, which states "Denied. Member enrollment file indicates BadgerCare Plus Benchmark or Core Plan member. Please submit claim to BadgerRx Gold."

Providers will receive National Council for Prescription Drug Programs reject code 70, which states "Product/service not covered," for real-time pharmacy claims for drugs that are not covered by the Core Plan.

Providers may refer to the Portal for a complete list of EOB codes and descriptions.

Noncovered Services

Compound drugs and oral contraceptives are not covered by the Core Plan.

Effective for DOS on and after July 1, 2009, oral antiretroviral drugs will not be covered for all Core Plan members.

Core Plan members do not have appeal rights for noncovered services.

Reimbursement

Providers will be reimbursed for covered drugs provided to members at the lesser of the provider's usual and customary charge or the current Wisconsin Medicaid

rate of reimbursement, plus the current Medicaid dispensing fee.

Copayment

Copayment for drugs covered by the Core Plan is up to $5.00 per prescription, per provider, with a monthly maximum of $20.00 per member, per provider, per month.

Under the Core Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Information for Transitioned Core Plan Members

Covered Services

Generally, covered pharmacy services and the policies and procedures for Core Plan members transitioned from GAMP and GA medical programs are the same as those for the newly enrolled Core Plan members, with a few exceptions.

Generic and OTC drugs covered by the Core Plan for transitioned members are the same as those covered by the Benchmark Plan, with the exception of generic oral contraceptives and oral antiretroviral drugs. Oral contraceptives were incorrectly listed as covered services by the Core Plan on the BadgerCare Plus Benchmark and Core Plan National Drug Code List on the Portal. The list has been revised to correct the information that oral contraceptives are not covered by the Core Plan.

Oral antiretroviral drugs are no longer covered by ForwardHealth for transitioned Core Plan members effective for DOS on and after July 1, 2009. In addition, ForwardHealth will enddate reimbursement by National Drug Code (NDC) for injectible antipsychotic drugs and hemophilia products for transitioned members on June 30, 2009.

For DOS from January 1, 2009, through June 30, 2009, Preferred Drug List (PDL) preferred *and* non-preferred drugs in the following classes were covered by the Core Plan for transitioned members:

- Anticonvulsants.
- Alzheimer's agents.
- Antidepressants, other.
- Antidepressants, selective serotonin reuptake inhibitor (SSRI).
- Antiparkinson's agents.
- Antipsychotics.
- Stimulants and related agents.
- Bronchodilators, beta agonists.
- Glucocorticoids, inhaled.
- Hypoglycemics, insulins.

Claims for these drug classes for transitioned members are exempt from the following policies for DOS from January 1, 2009, through June 30, 2009:

- Preferred Drug List PA requirements.
- Brand medically necessary policy PA requirements.
- Diagnosis restrictions, when applicable.

For the drug classes listed above, the Core Plan coverage polices will be enforced for DOS on and after July 1, 2009.

For DOS on and after July 1, 2009, PDL non-preferred brand name and non-preferred generic drugs in the previously listed classes will not be covered by the Core Plan, except for transitioned members who have been grandfathered on certain mental health drugs.

Grandfathering of Mental Health Drugs for Transitioned Members

Transitioned members who are currently taking mental health drugs in the following classes will be grandfathered on *any* drug in these classes as long as the member is enrolled in the Core Plan *and* until a generic equivalent is available:

- Alzheimer's agents.
- Atypical antipsychotics.

Transitioned members will be grandfathered on the *specific* drug they are currently taking in the following classes as long as the member is enrolled in the Core Plan *and* until a generic equivalent is available:

- Anticonvulsants.
- Antidepressants, other.
- Antidepressants, SSRI.
- Antiparkinson's agents.
- Stimulants and related agents.

Prior authorization is not required for transitioned members for a grandfathered drug or class, except when a generic equivalent drug becomes available for a brand name drug. Other policies (e.g., diagnosis restrictions) for these drugs and drug classes may apply. For classes grandfathered by drug, if a member must be switched to different drugs in these classes, generic drugs are covered. Other non-preferred brand name drugs are not covered by the Core Plan, but may be covered by BadgerRx Gold. Prior authorization is not available for other drugs (i.e., a drug the member is not taking) in the previously listed classes.

If a member has not been transitioned from GAMP or GA medical programs, the member will not be grandfathered on drugs he or she is currently taking. Grandfathered drugs are indicated on the Core Plan Brand Name Drug Quick Reference.

As a reminder, with the exception of PA policies, all policies (e.g., quantity limits, reimbursement) are the same for Core Plan members who are newly enrolled and transitioned as they are for the Standard Plan, the Benchmark Plan, Medicaid, and SeniorCare.

Brand Medically Necessary Mental Health Drugs for Grandfathered Transitioned Members

Transitioned members taking brand name drugs in any mental health drug class will not be grandfathered on the drug or in the class if the drug was considered a brand medically necessary drug before July 1, 2009. For example, members taking Prozac® for DOS before July 1, 2009, will not be grandfathered on Prozac® and instead must be dispensed fluoxetine or another generic antidepressant for DOS on and after July 1, 2009.

Brand medically necessary PA requests may be submitted only for the mental health drug or class for which the transitioned member has been grandfathered. If a brand name mental health drug is available in a generic equivalent, the transitioned member should receive the generic equivalent unless it is medically necessary for the member to receive the brand name drug. This is an exception to previously listed PA policy.

If a member is currently grandfathered on a brand name drug and a generic equivalent is released by the manufacturer, grandfathering of the brand name drug for the member will be discontinued when the brand name drug is added to the Brand Medically Necessary Drugs That Require Prior Authorization data table on the Pharmacy page of the Portal.

For example, in the antidepressants, SSRI drug class, if a member is currently grandfathered on Lexapro® and a generic equivalent is released, the prescriber should switch the member to the generic equivalent or to another generic drug in the antidepressant drug classes. If the generic equivalent does not work for the member and the brand name drug is medically necessary, the prescriber must submit a Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083 (10/08), to the pharmacy where the prescription will be filled. The pharmacy provider is required to submit the PA/BMNA, along with a completed PA/RF to ForwardHealth. The PA will be adjudicated using current Standard Plan brand medically necessary policy. Providers may refer to the Online Handbook for information about the brand medically necessary policy.

Providers may refer to the June 2008 *Update* (2008-40), titled "Brand Medically Necessary Prior Authorization

Requirements," for more information about brand medically necessary PA.

Injectible Antipsychotic Drugs and Hemophilia Products

Effective for DOS on and after July 1, 2009, provider-administered injectible antipsychotic drugs and hemophilia products are covered by the Core Plan for newly enrolled and transitioned members. Claims for injectible antipsychotic drugs and hemophilia products may be submitted on the 837 Health Care Claim: Professional transaction or on the 1500 Health Insurance Claim Form with a Healthcare Common Procedure Coding System (HCPCS) procedure code *and* an NDC. An NDC is required on claims to comply with the requirements of the Deficit Reduction Act of 2005.

Effective for DOS on and after July 1, 2009, pharmacy providers cannot submit claims for injectible antipsychotic drugs for Core Plan members with only an NDC indicated.

Currently, physicians are allowable provider types that may submit claims for antipsychotic drugs and hemophilia products with a HCPCS procedure code. Effective for DOS on and after July 1, 2009, pharmacy providers will be added as an allowable provider type to submit claims for injectible antipsychotic drugs and hemophilia products with a HCPCS procedure code.

Providers, with the exception of pharmacy providers, should indicate on claims an appropriate administration procedure code to receive reimbursement for administration of injectible antipsychotic drugs and hemophilia products.

Pharmacy providers should indicate an allowable procedure code, an NDC, *and* modifier "U1" on claims for injectible antipsychotic drugs and hemophilia products to receive reimbursement for the dispensing fee.

Refer to Attachment 8 for a list of allowable HCPCS procedure codes for antipsychotic drugs and hemophilia products. Pharmacy providers may submit claims for injectible antipsychotic drugs and hemophilia products for Core Plan members using the procedure codes listed in this attachment.

Emergency Medication Dispensing

The following are the only drugs for which emergency medication dispensing is allowed for all Core Plan members:

- Byetta and Symlin.
- Cytokine and CAM antagonists drugs.
- Provigil.
- Suboxone and Subutex.

In addition to the drugs listed above, emergency medication dispensing is allowed for a brand medically necessary mental health drug for which a transitioned member has been grandfathered.

ForwardHealth encourages pharmacy providers to dispense a 14-day emergency supply of a Core Plan-covered medication when they determine it is medically necessary or an emergency. An emergency medication supply may be dispensed if a member receives a prescription for a covered drug that requires PA and the physician cannot be reached to obtain a new prescription or the appropriate documentation to submit the PA request. Medications dispensed in an emergency do not require PA. Subsequent prescription refills require PA for these members.

Policies such as member enrollment and noncovered services still apply for emergency medication dispensing. Drugs used for treatment outside the approved diagnoses are considered noncovered services.

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim, F-13072 (10/08), with a Pharmacy Special Handling Request, F-13074 (10/08), indicating the nature

of the emergency. Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request form. Providers may also fax these forms to ForwardHealth at (608) 221-0885.

Providers may refer to the Online Handbook on the Portal for more information about emergency medication dispensing.

Coordination of Benefits

Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Drug Assistance Program Members

The Core Plan does *not* cover drugs in the antiretroviral drug class for members enrolled in the Core Plan. Claims for antiretroviral drugs for Core Plan members who are also enrolled in the Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Drug Assistance Program (ADAP) should be submitted to ADAP. For all other drugs, providers should submit claims first to the Core Plan, then to ADAP, and then to BadgerRx Gold.

Providers with questions may call ADAP at (800) 991-5532.

Wisconsin Chronic Disease Program Members

For members enrolled in the Core Plan and Wisconsin Chronic Disease Program (WCDP), providers should first submit a claim to the Core Plan if the drug is covered by the Core Plan. After a response from the Core Plan is received, the claim should be submitted to WCDP if the drug is covered by WCDP. Finally, the claim should be submitted to BadgerRx Gold, if appropriate.

HIRSP Members

Core Plan members may also be enrolled in the Health Insurance Risk Sharing Plan (HIRSP) as long as members meet the eligibility requirements for the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. HIRSP is always the payer of last resort.

For pharmacy services, providers should first submit claims to the Core Plan if drugs are covered by the Core Plan. After a response is received from the Core Plan, claims should be submitted to HIRSP if drugs are covered by HIRSP. Finally, claims should be submitted to BadgerRx Gold if appropriate.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Enrollment Verification Reminder

It is imperative that providers verify a member's enrollment to determine if the member is covered and in which plan the member is enrolled. Providers are reminded to *always* verify a member's enrollment *before* providing services, both to determine that the individual is enrolled for the current date and to discover any limitations to the member's coverage.

Providers have several options to obtain enrollment information through Wisconsin's Enrollment Verification System and should refer to the Online Handbook on the Portal for more information about enrollment. Providers may also refer to the December 2008 *Update* (2008-200), titled "Member Enrollment Verification for BadgerCare Plus Core Plan for Childless Adults," for more information.

For More Information

For more information or questions about the Core Plan, providers may refer to the following *Updates*:

- The June 2009 *Update* (2009-33), titled "Expansion of the BadgerCare Plus Core Plan for Adults with No Dependent Children."
- The December 2008 *Update* (2008-201), titled "Pharmacy Services Covered Under the BadgerCare Plus Core Plan for Childless Adults."
- The December 2008 *Update* (2008-216), titled "Provider-Administered Drugs for Members Enrolled in Managed Care Organizations Now Reimbursed by Fee-for-Service."

Information Regarding Medicaid HMOs

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid 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 (MCO). Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.

Members who are enrolled in WCDP only are not enrolled in MCOs.

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 Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Prior Authorization Drug Attachment for Provigil Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Provigil Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR PROVIGIL 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 (DHS 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 for Provigil form, F-00079, 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 — 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.

Element 3 — Date of Birth
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Strength
Check the strength of drug in milligrams.

Element 5 — Date Prescription Written
Enter the date that the prescription was written.

Element 6 — Refills
Enter the number of refills.

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 — Prescriber National Provider Identifier
Enter the 10-digit National Provider Identifier of the prescriber.

Element 10 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Providers are required to complete Section III and either Sections III A, III B, III C, or III D before signing the form.

Element 12 — Diagnosis 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 drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 13
Indicate whether or not the member is at least 16 years old.

Element 14
Indicate whether or not the member is currently taking any other stimulants.

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY

Element 15
Indicate whether or not the member has a diagnosis of Narcolepsy.

Element 16
Indicate whether or not the member has completed a polysomnogram (PSG). If yes, the results from a PSG **must** be submitted with this PA request for consideration.

Element 17
Indicate whether or not the member has taken a Multiple Sleep Latency Test (MSLT). If yes, the results from an MSLT **must** be submitted with this PA request for consideration.

SECTION III B — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME

Element 18
Indicate whether or not the member has a diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS).

Element 19
Indicate whether or not the member has completed a polysomnogram (PSG). If yes, the results from a PSG **must** be submitted with this PA request for consideration.

Element 20
Indicate the member's Apnea-Hypopnea Index (AHI) in events per hour.

Element 21
Indicate whether or not the member has tried Continuous Positive Airway Pressure (CPAP).

SECTION III C — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

Element 22
Indicate whether or not the member has a diagnosis of shift work sleep disorder.

Element 23
Indicate whether or not the member is a night-shift worker.

Element 24
Indicate whether or not the member is taking any hypnotics, sleep aids, or other medications that can cause sleepiness.

Element 25
Enter the member's current employer, along with his or her weekly work schedule.

SECTION III D — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER

Element 26
Indicate whether or not the member has a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).

Element 27
Indicate whether or not the member has a medical history of substance abuse or misuse. If yes, explain the substance abused and the current state of the member's usage of that substance. Also include any rehabilitation taken.

Element 28
Indicate whether or not the member poses a risk of drug diversion. If yes, explain what the member has done in the past to be considered a risk for diversion.

Element 29
Indicate whether or not the member has had a treatment failure or stopped taking Strattera due to a clinically significant adverse drug reaction. If yes, indicate the dates Strattera was taken and the reason for discontinuation.

SECTION IV — AUTHORIZED SIGNATURE

Element 30 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 31 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 32
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 2
Prior Authorization Drug Attachment for Provigil

(A copy of the "Prior Authorization Drug Attachment for Provigil" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00079 (06/09)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR PROVIGIL

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Provigil Completion Instructions, F-00079A, for more information.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth

SECTION II — PRESCRIPTION INFORMATION

4. Drug Strength (Check One)
   ❑ 100 mg ❑ 200 mg

5. Date Prescription Written

6. Refills

7. Directions for Use

8. Name — Prescriber

9. Prescriber National Provider Identifier

10. Address — Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Providers are required to complete Section III and either Sections IIIA, IIIB, IIIC, or IIID before signing this form.)

12. Diagnosis Code and Description

13. Is the member at least 16 years old? ❑ Yes ❑ No

14. Is the member taking any other stimulants? ❑ Yes ❑ No

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY

15. Does the member have a diagnosis of Narcolepsy? ❑ Yes ❑ No

16. Has the member had a Polysomnogram (PSG)? ❑ Yes ❑ No

17. Has the member had a Multiple Sleep Latency Test (MSLT)? ❑ Yes ❑ No

The results from the PSG and MSLT **must** be submitted with this PA request for consideration.

SECTION III B — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA / HYPOPNEA SYNDROME

18. Does the member have a diagnosis of Obstructive Sleep Apnea / Hypopnea Syndrome (OSAHS)? ❑ Yes ❑ No

19. Has the member had a Polysomnogram (PSG)? ❑ Yes ❑ No

20. What is the member's Apnea-Hypopnea Index (AHI)? _____ Events / Hour

21. Has the member tried Continuous Positive Airway Pressure (CPAP)? ❑ Yes ❑ No

The results from the PSG **must** be submitted with this PA request for consideration.

Continued

SECTION III C — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

22. Does the member have a diagnosis of shift work sleep disorder?	❑ Yes	❑ No
23. Is the member a night-shift worker?	❑ Yes	❑ No
24. Is the member taking any hypnotics, sleep aids, or other medications that can cause sleepiness?	❑ Yes	❑ No

25. State the member's employer and weekly work schedule.

SECTION III D — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER

26. Does the member have a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?	❑ Yes	❑ No
27. Does the member have a medical history of substance abuse or misuse?	❑ Yes	❑ No

If yes, explain in the space provided.

28. Does the member have a serious risk of diversion?	❑ Yes	❑ No

If yes, explain in the space provided.

29. Has the member experienced a treatment failure or a clinically significant adverse drug reaction with Strattera?	❑ Yes	❑ No

If yes, list the dates taken and the reason(s) for discontinuation.

SECTION IV — AUTHORIZED SIGNATURE

30. **SIGNATURE** — Prescriber	31. Date Signed

SECTION V — ADDITIONAL INFORMATION

32. Additional diagnostic and clinical information explaining the need for the drug requested may be included below.

ATTACHMENT 3
Prior Authorization Drug Attachment for Suboxone and Subutex Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Suboxone and Subutex Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SUBOXONE AND SUBUTEX 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 (DHS 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 for Suboxone and Subutex form, F-00081, 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 — 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.

Element 3 — Date of Birth
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Check the name of drug prescribed.

Element 5 — Drug Strength
Check the strength of drug in milligrams.

Element 6 — Date Prescription Written
Enter the date that the prescription was written.

Element 7 — Refills
Enter the number of refills.

Element 8 — Directions for Use
Enter the directions for use of the drug.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — Prescriber National Provider Identifier
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 11 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION IIIA — CLINICAL INFORMATION
This section must be completed for all requests for Suboxone and Subutex.

Element 13 — Diagnosis 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 drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member is at least 16 years old.

Element 15
Indicate whether or not the member has been diagnosed with opioid dependence.

Element 16
Indicate whether or not the member is currently nursing.

Element 17
Check yes if the prescriber is a Drug Addiction Treatment Act (DATA 2000)-waived physician, and enter “X” DEA number. Check no if prescriber does not participate in this program.

Element 18
Indicate whether or not the member is taking other opioids, tramadol, or carisoprodol.

Element 19
Indicate whether or not the member has any untreated or unstable psychiatric conditions that may interfere with compliance.

SECTION IIIB — CLINICAL INFORMATION (Complete for Subutex requests only.)

Element 20
Indicate whether or not the member is currently pregnant.

Element 21
Indicate whether or not the member is allergic to naloxone.

SECTION IV — ATTESTATION
The physician must read and sign the attestation statement for consideration of the PA request.

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 form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 24
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 4
Prior Authorization Drug Attachment for Suboxone and Subutex

(A copy of the "Prior Authorization Drug Attachment for Suboxone and Subutex" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00081 (06/09)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SUBOXONE AND SUBUTEX

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Suboxone and Subutex Completion Instructions, F-00081A, for more information.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name (Check One) ❑ Suboxone ❑ Subutex	5. Drug Strength (Check Strength[s]) ❑ 2 mg ❑ 8 mg
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. Prescriber National Provider Identifier
11. Address — Prescriber (Street, City, State, ZIP+4 Code)	12. Telephone Number — Prescriber

SECTION IIIA — CLINICAL INFORMATION (Required for all requests.)

13. Diagnosis Code and Description

14. Is the member at least 16 years old?	❑ Yes	❑ No
15. Does the member have a diagnosis of opioid dependence?	❑ Yes	❑ No
16. If female, is the member nursing?	❑ Yes	❑ No
17. Does the physician have a valid Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone and Subutex for opioid dependence? If yes, enter the physician's "X" DEA number in the space provided.	❑ Yes	❑ No
18. Is the member taking any other opioids, tramadol, or carisoprodol?	❑ Yes	❑ No
19. Does the member have any untreated or unstable psychiatric conditions that may interfere with compliance?	❑ Yes	❑ No

SECTION IIIB — CLINICAL INFORMATION (Complete for Subutex request only.)

20. Is the member pregnant?	❑ Yes	❑ No
21. Does the member have a documented allergy to naloxone?	❑ Yes	❑ No

Continued

SECTION IV — ATTESTATION

The U.S. Department of Health and Human Services endorses the Federation of State Medical Boards – Model Policy Guidelines for Opioid Addiction Treatment. The prescribing physician agrees to follow these guidelines, including:

- The patient should receive opioids from only one physician and/or pharmacy when possible.
- The physician should employ the use of a written agreement between the physician and patient addressing issues such as:
  - Alternative treatment options.
  - Regular toxicologic testing for drugs of abuse and therapeutic drug levels.
  - Number and frequency of all prescription refills.
  - Reasons for which drug therapy may be discontinued.
- Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objective such as:
  - Absence of toxicity.
  - Absence of medical or behavioral adverse effects.
  - Responsible handling of medications.
  - Compliance with all elements of the treatment plan, including recovery-oriented activities, psychotherapy, and/or psychosocial modalities.
  - Abstinence from illicit drug use.

By signing this form, the prescribing physician agrees to follow the guidelines set forth by the State Medical Boards for Opioid Addiction Treatment.

22. **SIGNATURE** — Prescriber	23. Date Signed

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 5
Prior Authorization Drug Attachment for Byetta and Symlin Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Byetta and Symlin Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BYETTA AND SYMLIN 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 (DHS 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 for Byetta and Symlin form, F-00080, 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 — 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.

Element 3 — Date of Birth
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name and Strength
Check the name and strength of drug.

Element 5 — Date Prescription Written
Enter the date that 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 — Prescriber National Provider Identifier
Enter the 10-digit National Provider Identifier of the prescriber.

Element 9 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 10 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION
Providers are required to complete Section III and either Section III A or III B before signing and dating the form.

Element 11 — Diagnosis 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 drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 12
Enter member's last Hemoglobin A1c (HbA1c) test results.

Element 13 — Date Member's HbA1c Measured
Enter the date of the HbA1c test from Element 12.

Element 14
Indicate whether or not the member is using the medication for weight loss.

Element 15
Indicate whether or not the member is currently using Byetta.

Element 16
Indicate whether or not the member is currently using Symlin.

SECTION III A — CLINICAL INFORMATION FOR BYETTA®

Element 17
Indicate whether or not the member has a diagnosis of Type II Diabetes.

Element 18
Indicate whether or not the member is at least 18 years old.

Element 19
Indicate whether or not the member is currently taking a sulfonylurea. If yes, indicate the drug name, dose, and directions for use.

Element 20
Indicate whether or not the member was unable to tolerate the maximum dose of a sulfonylurea due to a clinically significant adverse drug reaction. If yes, list the drug name, the dose the member was able to titrate to, and the adverse reaction that occurred.

Element 21
Indicate whether or not the member has failed to achieve adequate glycemic control at the maximum dose of a sulfonylurea. If yes, indicate the drug on which the member failed, the dose, and directions for use.

Element 22
Indicate whether or not the member is currently taking metformin. If yes, indicate the dose and directions for use.

Element 23
Indicate whether or not the member is unable to tolerate the maximum dose of metformin due to a clinically significant adverse drug reaction. If yes, list the dose the member was able to titrate to, and the adverse reaction that occurred.

Element 24
Indicate whether or not the member has failed to achieve adequate glycemic control at the maximum dose of metformin. If yes, indicate the dose and directions for use.

Element 25
Indicate whether or not the member is currently taking a thiazolidinedione. If yes, indicate the drug name, dose, and directions for use.

Element 26
Indicate whether or not the member is unable to tolerate the maximum dose of a thiazolidinedione due to a clinically significant adverse drug reaction. If yes, list the drug name, the dose the member was able to titrate to, and the adverse reaction that occurred.

Element 27
Indicate whether or not the member has failed to achieve adequate glycemic control at the maximum dose of a thiazolidinedione. If yes, indicate the drug on which the member failed, the dose, and directions for use.

SECTION III B — CLINICAL INFORMATION FOR SYMLIN®

Element 28
Indicate whether or not the member is currently taking insulin to control Type I Diabetes.

Element 29
Indicate whether or not the member is currently taking insulin to control Type II Diabetes.

Element 30
Indicate whether or not the member is at least 15 years old.

Element 31
Indicate whether or not the member is currently using an insulin pump.

Element 32
If the member is currently taking insulin, indicate each type of insulin he or she is taking and include the number of units and dosing frequency for each type.

Element 33
Indicate whether or not the member has gastroparesis.

Element 34
Indicate whether or not the member has hypoglycemia unawareness.

Element 35
Indicate whether or not the member has required emergency treatment for severe hypoglycemia in the past six months. If yes, list how many different occasions he or she required emergency treatment in the past six months.

SECTION IV — AUTHORIZED SIGNATURE

Element 36 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 37 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 38
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 6
Prior Authorization Drug Attachment for Byetta and Symlin

(A copy of the "Prior Authorization Drug Attachment for Byetta and Symlin" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00080 (06/09)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BYETTA AND SYMLIN

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Byetta and Symlin Completion Instructions, F-00080A.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name and Strength (Check One)

❑ SymlinPen 60 ❑ SymlinPen 120 ❑ Symlin 5 ml vial ❑ Byetta 5 mcg ❑ Byetta 10 mcg

5. Date Prescription Written

6. Directions for Use

7. Name — Prescriber

8. Prescriber National Provider Identifier

9. Address — Prescriber (Street, City, State, ZIP+4 Code)

10. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

Providers are required to complete Section III and either Section III A or III B before signing and dating this form.

11. Diagnosis Code and Description

12. State the member's most current HbA1c. _____ %

13. Date Member's HbA1c Measured

14. Is the member using the medication for weight loss? ❑ Yes ❑ No

15. Is the member currently using Byetta? ❑ Yes ❑ No

16. Is the member currently using Symlin? ❑ Yes ❑ No

SECTION III A — CLINICAL INFORMATION FOR BYETTA®

17. Does the member have a diagnosis of Type II Diabetes? ❑ Yes ❑ No

18. Is the member at least 18 years old? ❑ Yes ❑ No

19. Is the member currently taking a sulfonylurea? ❑ Yes ❑ No

If yes, indicate the drug name, dose, and directions for use in the space provided.

20. Is the member unable to tolerate the maximum dose of a sulfonylurea due to a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the drug name, dose, and adverse reaction in the space provided.

Continued

SECTION III A — CLINICAL INFORMATION FOR BYETTA® (Continued)

21. Has the member failed to achieve adequate glycemic control at the maximum dose of a sulfonyurea? ❑ Yes ❑ No

If yes, indicate the drug, dose, and directions for use in the space provided.

❑ Glyburide
dose _____ directions for use _____

❑ Glipizide
dose _____ directions for use _____

❑ Glimepiride
dose _____ directions for use _____

22. Is the member currently taking metformin? ❑ Yes ❑ No

If yes, indicate the dose and directions for use in the space provided.

23. Is the member unable to tolerate the maximum dose of metformin due to a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the dose and adverse reaction in the space provided.

24. Has the member failed to achieve adequate glycemic control at the maximum dose of metformin? ❑ Yes ❑ No

If yes, indicate the dose and directions for use in the space provided.

25. Is the member currently taking a thiazolidinedione? ❑ Yes ❑ No

If yes, indicate the drug name, dose, and directions for use in the space provided.

26. Is the member unable to tolerate the maximum dose of a thiazolidinedione due to a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the drug name, dose, and adverse reaction in the space provided.

27. Has the member failed to achieve adequate glycemic control at the maximum dose of a thiazolidinedione? ❑ Yes ❑ No

If yes, indicate the drug, dose, and directions for use in the space provided.

❑ Actos
dose _____ directions for use _____

❑ Avandia
dose _____ directions for use _____

Continued

SECTION III B — CLINICAL INFORMATION FOR SYMLIN®

28. Is the member taking insulin for Type I Diabetes?	❑ Yes	❑ No
29. Is the member taking insulin for Type II Diabetes?	❑ Yes	❑ No
30. Is the member at least 15 years old?	❑ Yes	❑ No
31. Is the member using an insulin pump?	❑ Yes	❑ No

32. If the member is taking insulin, indicate their regimen in the space provided.

Insulin type _____ Number of Units _____ Directions for Use _____

Insulin type _____ Number of Units _____ Directions for Use _____

Insulin type _____ Number of Units _____ Directions for Use _____

33. Does the member have gastroparesis?	❑ Yes	❑ No
34. Does the member have hypoglycemia unawareness?	❑ Yes	❑ No
35. Has the member required emergency treatment for severe hypoglycemia in the past six months?	❑ Yes	❑ No

If yes, how many times?

SECTION IV — AUTHORIZED SIGNATURE

36. **SIGNATURE** — Prescriber	37. Date Signed

SECTION V — ADDITIONAL INFORMATION

38. Additional diagnostic and clinical information explaining the need for the drug requested may be included below.

ATTACHMENT 7
HCPCS Procedure Codes for Injectible Antipsychotic Drugs and Hemophilia Products

The following Healthcare Common Procedure Coding System (HCPCS) procedures codes are allowable on claims for injectible antipsychotic drugs and hemophilia products.

Mental Health Drug Procedure Codes	
Code	**Description**
J0400	Injection, aripiprazole, intramuscular, 0.25 mg
J1630	Injection, haloperidol, up to 5 mg
J1631	Injection, haloperidol decanoate, per 50 mg
J2680	Injection, fluphenazine deconoate, [Prolixin Deconoate], up to 25mg
J2794	Injection, risperidone, long acting, 0.5 Mg
J3486	Injection, ziprasidone mesylate, 10 mg
J3490*	Unclassified drugs

* Pharmacy providers may indicate procedure code J3490 only on claims for intramuscular olanzapine.

Hemophilia Drug Procedure Codes	
Code	**Description**
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII IU
J7187	Injection, von willebrand factor complex (Humate-p), per IU VWF:RCO
J7189	Factor VIIA (antihemophilic factor, recombinant), per 1 microgram
J7190	Factor VIII (antihemophilic factor, human), per IU
J7192	Factor VIII (antihemophilic factor, recombinant), per IU
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per IU
Q2023	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per IU