ForwardHealth
Wisconsin serving you

Update
September 2009

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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Dentists, Federally Qualified Health Centers, Home Health Agencies, Nurse Practitioners, Nurses in Independent Practice, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

New Prior Authorization Criteria for Lovaza®

Effective for dates of service on and after November 1, 2009, Lovaza® will be a preferred drug that has clinical prior authorization (PA) requirements. This *ForwardHealth Update* describes PA approval criteria and PA request submission options, including submitting PA requests for Lovaza® through the Drug Authorization and Policy Override Center.

Effective for dates of service (DOS) on and after November 1, 2009, Lovaza® will be a preferred drug that requires clinical prior authorization (PA). Current, approved PAs will be honored until their expiration date. For members to continue taking Lovaza® beyond an approved PA's expiration date, a new PA must be submitted following the criteria and procedures in this *ForwardHealth Update*.

Information in this *Update* applies to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare. Lovaza® is not covered for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan for Adults with No Dependent Children.

Requesting Prior Authorization for Lovaza®

Prior authorization for Lovaza® must be requested by prescribers or their designees, *not* pharmacy providers.

Prescribers or their billing providers are required to be certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and National Provider Identifier (NPI) as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

Prior authorization requests for anti-obesity drugs may be submitted through the Drug Authorization and Policy Override (DAPO) Center or by fax or mail.

Note: Pharmacy providers can no longer request PA for Lovaza® using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system. If a PA request for Lovaza® is submitted using the STAT-PA system for DOS on and after November 1, 2009, providers will receive a message that states, "Procedure not valid for STAT-PA."

New Prior Authorization Drug Attachment

ForwardHealth has created the Prior Authorization Drug Attachment for Lovaza®, F-00162 (09/09). Prescribers may refer to Attachments 1 and 2 of this *Update* for the Prior Authorization Drug Attachment for Lovaza® form and completion instructions.

Submitting Prior Authorization Requests Through the Drug Authorization and Policy Override Center

Prescribers or their designees are encouraged to call the DAPO Center to request PA for Lovaza®. Prescribers may contact the DAPO Center at (800) 947-9627 from 8:00 a.m. to 5:30 p.m. (Central Time), Monday through Friday, except holidays. After business hours, prescribers may leave a voicemail message for DAPO Center staff to return the next business day.

When calling the DAPO Center, a pharmacy technician will ask prescribers a series of questions based on the Prior Authorization Drug Attachment for Lovaza®. Prescribers are encouraged to have the Prior Authorization Drug Attachment for Lovaza® completed or the member's medical record available when they call the DAPO Center. Drug Authorization and Policy Override Center staff will ask for the name of the caller and the caller's credentials. (i.e., Is the caller a registered nurse, physician's assistant, or certified medical assistant?)

Generally by the end of the call, if clinical PA criteria are met, DAPO Center staff will approve the PA request based on the information provided by the caller. If the PA request is approved, a decision notice letter will be mailed to the billing provider. After a PA has been approved, the prescriber should send the prescription to the pharmacy and the member can pick up the drug. The member does not need to wait for the prescriber to receive the decision notice to pick up the drug at the pharmacy.

As a reminder, only the provider listed as the billing provider can view and amend PA requests on the ForwardHealth Portal.

Note: If a provider receives a decision notice letter for a drug for which he or she did not request PA, the provider should notify the DAPO Center within 14 days of receiving the letter to inactivate the PA.

If a prescriber or his or her designee calls the DAPO Center to request PA and the clinical criteria for the PA are not met, the caller will be informed that the PA request is not approved because it does not meet the clinical criteria. If the prescriber chooses to submit additional medical documentation for consideration, he or she may submit the PA request to ForwardHealth for review by a pharmacist. The prescriber is required to submit a Prior Authorization Request Form (PA/RF), F-11018 (10/08), and the Prior Authorization Drug Attachment for Lovaza® form with the additional medical documentation. Documentation may be submitted to ForwardHealth through the Portal or by fax or mail. Providers may refer to Attachment 3 for the PA/RF instructions for physicians submitting PA requests for drugs.

Providers may refer to the ForwardHealth Online Handbook on the Portal for more information about the DAPO Center.

Submitting Prior Authorization Requests by Fax or Mail

Prescribers may also submit PA requests for Lovaza ® by fax to (608) 221-8616 or by mail to the following address:

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

If a prescriber or his or her designee chooses to submit a paper PA request for Lovaza® by fax or mail, prescribers are required to complete and submit the following to ForwardHealth:

- Prior Authorization Request Form.
- Prior Authorization Drug Attachment for Lovaza®.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet, F-1176 (10/08), is available on the Forms page of the Portal for

providers submitting the forms and documentation by fax.

Prior authorization requests for Lovaza® submitted by mail or fax will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

Clinical Criteria

Clinical criteria for approval of a PA request for Lovaza® are the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- Medical conditions (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia have been identified and are being managed appropriately.
- Medications (e.g., beta blockers, thiazides, estrogens) that may contribute to hypertriglyceremia have been identified and modified if appropriate.
- The member is aware of and compliant with lifestyle modifications (e.g., diet, exercise, weight loss, alcohol consumption) that may improve triglyceride levels.
- The member currently has a triglyceride level of 500 mg/dL or greater, or for members with triglyceride levels below 500 mg/dL, the member must have both of the following:
  - ✓ A triglyceride level of 500 mg/dL or greater within the last five years. (*Note:* The test date of the triglyceride level must be indicated on the PA request.)
  - ✓ A current triglyceride level between 200 and 499 mg/dL while taking a fibrate or niacin. If a member's triglyceride level is below 200 mg/dL, a PA request will be denied.

Approved Prior Authorization Requests

If an initial PA request for Lovaza® is approved, the request will be approved for four months. For subsequent PA requests, the member's triglyceride levels must decrease by 20 percent from the baseline triglyceride level for a renewal PA request to be approved. Renewal requests may be approved for up to one year.

Lipid panels, including triglyceride levels, are required for each yearly PA renewal request thereafter.

Information Regarding Managed Care Organizations

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. Medicaid and BadgerCare Plus HMOs 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 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 Lovaza®
Completion Instructions

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

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LOVAZA®
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 service.

Prior authorization requests for Lovaza® submitted on paper require the use of this form. 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 Drug Attachment for Lovaza® form, F-00162, to request PA for Lovaza®. Prescribers are required to retain a completed copy of the form.

Prescribers may submit PA requests on a PA drug attachment form in one of the following ways:

1) For requests submitted through the Drug Authorization and Policy Override Center, prescribers may call (800) 947-9627.

2) For paper PA requests by fax, prescribers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment to ForwardHealth at (608) 221-8616.

3) For paper PA requests by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment 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 AND PROVIDER 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 — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 4 — Name — Prescriber
Enter the name of the prescribing provider.

Element 5 — National Provider Identifier (NPI) — Prescriber
Enter the prescribing provider's National Provider Identifier (NPI).

Element 6 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 8 — Name — Billing Provider
Enter the name of the billing provider. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on the PA request. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on the PA request.

Element 9 — NPI — Billing Provider
Enter the billing provider's NPI.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name
This element is populated with Lovaza®.

Element 11 — Drug Strength
Enter the strength of the Lovaza® prescribed to the member.

Element 12 — Date Prescription Written
Enter the date the prescription was written.

Element 13 — Directions for Use
Enter the directions for use of the drug.

Element 14 — Refills
Enter the number of refills.

SECTION III — CLINICAL INFORMATION

Confirm that the information submitted in this section is the most current.

Element 15 — Diagnosis Code and Description
Enter the most specific *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 16
Enter the member's most recent lipid panel.

Element 17
Enter the date the member's most recent lipid panel was taken.

SECTION IV — INITIAL COVERAGE REQUIREMENTS

Element 18
Indicate whether or not the member has an allergy or sensitivity to fish.

Element 19
Indicate whether or not the member has a medical condition (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia.

Element 20
Indicate whether or not the member is taking a medication (e.g., beta blocker, thiazide, estrogen) that may contribute to hypertriglyceremia.

Element 21
Indicate whether or not the prescriber has evaluated and discussed lifestyle changes (e.g., diet, exercise, weight loss, alcohol consumption) with the member that may improve triglyceride levels.

Element 22
List the member's current lipid- and triglyceride-lowering therapies, including all medication names, daily doses, and start dates.

Element 23
Indicate whether or not the member's triglyceride level has been 500 mg/dL or greater in the past five years. If yes, enter the triglyceride level and date of the test.

SECTION V — AUTHORIZED SIGNATURE

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 form was signed in MM/DD/CCYY format.

SECTION VI — 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 be included here.

SECTION VII — INTERNAL USE ONLY
This section is for internal use only.

ATTACHMENT 2
Prior Authorization Drug Attachment for Lovaza®

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00162 (09/09)

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 LOVAZA®

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Lovaza® Completion Instructions, F-00162I, for more information.

Providers may call the Drug Authorization and Policy Override Center at (800) 947-9627 with questions.

SECTION I — MEMBER AND PROVIDER INFORMATION

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

2. Member Identification Number	3. Date of Birth — Member
4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber
6. Address — Prescriber (Street, City, State, ZIP+4 Code)	7. Telephone Number — Prescriber
8. Name — Billing Provider	9. NPI — Billing Provider

SECTION II — PRESCRIPTION INFORMATION

10. Drug Name
Lovaza

11. Drug Strength	12 Date Prescription Written
13. Directions for Use	14. Refills

SECTION III — CLINICAL INFORMATION

15. Diagnosis Code and Description

16. List the member's most recent lipid panel and date taken.

Total Cholesterol _____

High-density lipoprotein (HDL) cholesterol _____

Low-density lipoprotein (LDL) cholesterol _____

Triglyceride _____

17. Indicate the date of the lipid panel.

SECTION IV — INITIAL COVERAGE REQUIREMENTS

18. Does the member have an allergy or sensitivity to fish?	❑ Yes	❑ No
19. Does the member have a medical condition (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia?	❑ Yes	❑ No
If yes, is the member compliant with the prescribed treatment?	❑ Yes	❑ No
20. Is the member taking a medication (e.g., beta blocker, thiazide, estrogen) that may contribute to hypertriglyceremia?	❑ Yes	❑ No
If yes, has the medication been evaluated and modified if appropriate?	❑ Yes	❑ No

Continued

SECTION IV — INITIAL COVERAGE REQUIREMENTS (Continued)

21. Has the prescriber evaluated and discussed lifestyle modifications (e.g., diet, exercise, weight loss, alcohol consumption) with the member that may improve his or her triglyceride levels? ❑ Yes ❑ No

22. List the member's current lipid- and triglyceride-lowering therapy, including all medication names, daily doses, and start dates.

23. Has the member's triglyceride level been 500 mg/dL or greater in the past five years? ❑ Yes ❑ No

If yes, provide the triglyceride level and the date of the test.

SECTION V — AUTHORIZED SIGNATURE

24. **SIGNATURE** — Prescriber	25. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

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

SECTION VII — FOR INTERNAL USE ONLY

- ❑ Initial request — Four months for members with current triglyceride levels of 500 mg/dL and above.
- ❑ Initial request — Four months for members with current triglyceride levels between 200 and 499 mg/dL who are taking a fibrate or niacin *and* have a triglyceride level over 500 mg/dL in the past five years.
- ❑ Renewal request — 12 months for members whose triglyceride level decreased or is maintained at a minimum of 20 percent below baseline.

ATTACHMENT 3
Prior Authorization Request Form (PA/RF) Completion Instructions Submitted by Prescribers for Drugs

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. 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 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)
Leave the box next to HealthCheck "Other Services" blank. Enter an "X" in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the Prior Authorization Request Form (PA/RF), F-11018 (10/09), are for a WCDP member.

Element 2 — Process Type
Enter process type 131 — Drugs. The process type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no process type is indicated.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are *not* certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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 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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are *not* certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are *not* certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are *not* certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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 of service in MM/DD/CCYY format.

Element 16 — Rendering Provider Number
Enter the prescriber's NPI, *only* if the NPI is different from the NPI of the billing provider listed in Element 5a.

Element 17 — Rendering Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the prescriber *only* if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 18 — Procedure Code (not required)

Element 19 — Modifiers (not required)

Element 20 — POS
Enter the National Council for Prescription Drug Programs (NCPDP) patient location code of "0" (Not Specified).

Element 21 — Description of Service
Enter the drug name and dose for each item requested (e.g., drug name, milligrams, capsules).

Element 22 — QR
Enter the appropriate quantity (e.g., days' supply) requested for each item requested.

Element 23 — Charge (not required)

Element 24 — Total Charges (not required)

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting this 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).