

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare

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

Prior Authorization Procedures for Anti-Obesity Drugs

This *ForwardHealth Update* includes revised procedures for requesting prior authorization for anti-obesity drugs.

Effective for dates of service (DOS) on and after November 1, 2009, procedures to obtain prior authorization (PA) for the following anti-obesity drugs will change:

- Diethylpropion.
- Meridia.
- Phentermine.
- Phendimetrazine.
- Xenical.

Current, approved PAs will be honored until their expiration date. For members to continue taking an anti-obesity drug beyond an approved PA's expiration date, a new PA must be submitted following the criteria and procedures in this *ForwardHealth Update*.

Procedures in this *Update* for submitting PA requests for anti-obesity drugs apply to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Note: Anti-obesity drugs are not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan for Adults with No Dependent Children, or Medicare Part D.

Requesting Prior Authorization for Anti-Obesity Drugs

Prior authorization for anti-obesity drugs 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 anti-obesity drugs using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system. If a PA request for anti-obesity drugs 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."

A 34-day supply is the maximum amount of any anti-obesity drug that may be dispensed each month.

New Prior Authorization Drug Attachment

ForwardHealth has created the Prior Authorization Drug Attachment for Anti-Obesity Drugs, F-00163 (09/09). This form replaces the Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs, F-11061 (10/08).

Prior authorization requests for anti-obesity drugs received by ForwardHealth on and after November 1, 2009, must include the new Prior Authorization Drug Attachment for Anti-Obesity Drugs. If a PA request for anti-obesity drugs is received by ForwardHealth on and after November 1, 2009, with the Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs form, the PA will be returned to the provider unprocessed. Prior authorization requests for anti-obesity drugs submitted on the Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs will be processed if they are received by ForwardHealth by October 31, 2009.

Providers may refer to Attachments 1 and 2 of this *Update* for the Prior Authorization Drug Attachment for Anti-Obesity Drugs.

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 anti-obesity drugs. 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 Anti-Obesity

Drugs. Prescribers are encouraged to have the Prior Authorization Drug Attachment for Anti-Obesity Drugs 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 Anti-Obesity Drugs 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 prescribers 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 anti-obesity drugs 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 anti-obesity drugs by fax or mail, the following must be completed and submitted to ForwardHealth:

- Prior Authorization Request Form.
- Prior Authorization Drug Attachment for Anti-Obesity Drugs.
- 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 anti-obesity drugs 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 anti-obesity drugs are the following:

- The member has a body mass index (BMI) greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 and two or more of the following risk factors:
 - ✓ Coronary heart disease.
 - ✓ Dyslipidemia.
 - ✓ Hypertension.
 - ✓ Sleep apnea.
 - ✓ Type II diabetes mellitus.
- The member is 16 years of age or older. (*Note:* Members are required to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The member does not have a medical contraindication to the selected medication.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, exercise regimen, calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

Prior authorization requests for anti-obesity drugs will not be renewed if a member's BMI is below 24.

Note: ForwardHealth does not cover the brand name (i.e., innovator) anti-obesity drug if a Food and Drug Administration (FDA)-approved generic equivalent is available. In addition, ForwardHealth does not cover over-the-counter (OTC) anti-obesity drugs.

ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents as noncovered services.

Diethylpropion, Phendimetrazine, and Phentermine

If clinical criteria are met, initial PA requests for diethylpropion, phendimetrazine, and phentermine will be approved for three months. If the member meets a weight loss goal of at least 10 pounds during the initial three month approval, PA may be requested for an additional three months of treatment. The maximum length of continuous drug therapy for diethylpropion, phendimetrazine, and phentermine is six months.

If the member does not meet a weight loss goal of at least 10 pounds during the initial three month approval, the member must wait six months before PA is requested for any anti-obesity drug.

ForwardHealth allows only two weight loss attempts with this group of drugs (diethylpropion, phendimetrazine, and phentermine) during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

Meridia® and Xenical®

If clinical criteria are met, initial PA requests for Meridia® (sibutramine) or Xenical® (orlistat) will be approved for three months. If the member does not meet a weight loss goal of at least 10 pounds during the initial three-month approval, PA may only be requested for an additional three months of treatment. If the member meets a weight loss goal of at least 10 pounds during the combined six months of treatment, PA may be requested for an additional six months of treatment. If the member continues to lose weight, subsequent PA renewal periods for Meridia® and Xenical® are a maximum of six months.

If the member meets a weight loss goal of at least 10 pounds during the initial three-month approval, PA may be requested for an additional six months of treatment. If the member continues to lose weight, subsequent PA renewal periods are a maximum of six months. If the member does not lose weight during two consecutive PA

renewal periods, the member must wait six months before the provider submits a PA request for any anti-obesity drug.

Prior authorization requests for Meridia® and Xenical® may be approved for a maximum treatment period of 24 continuous months of drug therapy. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

ForwardHealth allows only two weight loss attempts with Meridia® and Xenical® during a member's lifetime.

If a member has reached his or her goal weight and continues treatment with Meridia® or Xenical® to maintain weight loss, a PA request may be approved for a maximum of six months if the member does not gain weight during the PA renewal period and the maximum treatment period of 24 months of drug therapy is not exceeded.

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 Anti-Obesity Drugs Completion Instructions

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

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR 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 (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 anti-obesity drugs 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 Anti-Obesity Drugs form, F-00163, to request PA for anti-obesity drugs. 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 form 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 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 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 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 billing provider's NPI.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name

Check the box with the name of the appropriate drug.

Element 11 — Drug Strength

Enter the strength of the drug listed in Element 10.

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

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 — Height — Member

Enter the member's height in inches.

Element 17 — Weight — Member

Enter the member's weight in pounds.

Element 18 — Date Member's Weight Was Measured

Enter the date the member's weight was measured in MM/DD/CCYY format.

Element 19 — Body Mass Index (BMI) — Member

Enter the member's current body mass index (BMI) using the following equation.

$$\text{BMI} = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$$

Example: Height = 5'9"

Weight = 230 lbs

Figure out height in inches: $5 \times 12 = 60 + 9 = 69$

$$\text{BMI} = \frac{703 \times 230}{69^2}$$

$$\text{BMI} = \frac{161690}{4761}$$

$$\text{BMI} = 33.96$$

Element 20 — Goal Weight — Member

Enter the member's goal weight in pounds. This should be a number agreed upon by the prescribing medical practitioner and the member.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

Complete this section for initial and renewal requests for anti-obesity drugs.

Element 21

Indicate whether or not the member is pregnant or nursing.

Element 22

Indicate whether or not the member has a history of an eating disorder (e.g., anorexia, bulimia).

Element 23

Indicate the medication prescribed for the member. In addition, answer the questions below the drug name that apply to the member's medical history.

SECTION IV B — INITIAL COVERAGE REQUIREMENTS

Complete this section for initial requests for anti-obesity drugs.

Element 24

Indicate whether or not the member's BMI is greater than or equal to 30 or greater than or equal to 27 but less than 30 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, or type II diabetes mellitus. If applicable, indicate the member's current risk factors.

Element 25

Indicate whether or not the member has participated in a weight loss treatment plan in the past six months and if the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan.

SECTION V — AUTHORIZED SIGNATURE

Element 26 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 27 — Date Signed

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

SECTION VI — 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.

SECTION VII — INTERNAL USE ONLY

This section is for internal use only.

ATTACHMENT 2

Prior Authorization Drug Attachment for Anti-Obesity Drugs

(A "Prior Authorization Drug Attachment for Anti-Obesity Drugs" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

Instructions: Type or print clearly. Before completing this form, read Prior Authorization Drug Attachment for Anti-Obesity Drugs Completion Instructions, F-00163I.

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 (Check only one.) <input type="checkbox"/> Xenical® (orlistat) <input type="checkbox"/> Meridia® (sibutramine) <input type="checkbox"/> diethylpropion <input type="checkbox"/> phentermine <input type="checkbox"/> phendimetrazine | |
| 11. Drug Strength | 12. Date Prescription Written |
| 13. Directions for Use | 14. Refills |

SECTION III — CLINICAL INFORMATION

| | |
|---------------------------------------|--|
| 15. Diagnosis Code and Description | |
| 16. Height — Member (Inches) | 17. Weight — Member (Pounds) |
| 18. Date Member's Weight Was Measured | 19. Body Mass Index (BMI) — Member (lb / in ²) |
| 20. Goal Weight — Member (Pounds) | BMI = $\frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$ |

For an initial drug request, the provider should complete Section IV A and Section IV B. For a renewal drug request, the provider should complete Section IV A.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

| | |
|---|--|
| 21. Is the member pregnant or nursing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Does the member have a history of an eating disorder (e.g., anorexia, bulimia)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Continued



SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS (Continued)

23. Medication Contraindications (Check either A, B, or C and answer the questions that follow.)

- A. Xenical® (orlistat)
- Does the member have chronic malabsorption syndrome? Yes No
 - Does the member have cholestasis? Yes No
- B. Meridia® (sibutramine)
- Has the member taken any monoamine oxidase inhibitors (MAOIs) within the past 14 days? Yes No
 - Is the member taking any other centrally acting weight loss drugs? Yes No
- C. Phendimetrazine, phentermine, or diethylpropion
- Does the member have glaucoma? Yes No
 - Does the member have hyperthyroidism? Yes No
 - Does the member have advanced arteriosclerosis? Yes No
 - Does the member have a history of drug abuse or misuse? Yes No
 - Does the member have uncontrolled hypertension? Yes No
 - Is the member hypersensitive to any sympathomimetic amines? Yes No

SECTION IV B — INITIAL COVERAGE REQUIREMENTS

24. Body Mass Index Requirements (Check A or B.)

- A. The member's BMI is greater than or equal to 30.
- B. The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors.
Check the member's current risk factors.
- Coronary Heart Disease.
 - Dyslipidemia.
 - Hypertension.
 - Sleep Apnea.
 - Type II Diabetes Mellitus.

25. Has the member participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will member continue to follow this treatment plan while taking an anti-obesity drug? Yes No

If yes, describe the treatment plan in the space provided.

SECTION V — AUTHORIZED SIGNATURE

26. SIGNATURE — Prescriber

27. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

28. 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.
 - Renewal request (Meridia® or Xenical®).
 - Renewal request (diethylpropion, phendimetrazine, or phentermine).
-

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).