ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Blood Banks, Dentists, Dispensing Physicians, Federally Qualified Health Centers, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Fall 2009 Preferred Drug List Review

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List (PDL). The fall 2009 PDL will be implemented in two phases. Phase I is effective for dates of service (DOS) on and after October 1, 2009, and Phase II is effective for DOS on and after November 16, 2009.

As a result of the fall 2009 PDL review, changes will occur to the PDL for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan for Adults with No Dependent Children.

For the fall 2009 Preferred Drug List (PDL) review, ForwardHealth has added two new drug classes to the PDL and reviewed 40 existing drug classes. The review may result in a change in status to preferred and non-preferred drugs in reviewed drug classes effective for dates of service (DOS) on and after October 1, 2009, for the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan for Adults with No Dependent Children, Medicaid, and SeniorCare.

This *ForwardHealth Update* provides an overview of the major changes to certain drug classes but does not address changes made in all drug classes. For DOS on and after October 1, 2009, providers should refer to the Wisconsin Medicaid, BadgerCare Plus, and SeniorCare Preferred Drug List — Quick Reference on the Pharmacy page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for the complete list of preferred and non-preferred drugs, including any changes in status, on the PDL.

The PDL is not a drug formulary and is not a comprehensive list of drugs that are covered by the Standard Plan, Medicaid, and SeniorCare. Most drugs and drug classes are covered by the Standard Plan, Medicaid, and SeniorCare, but some drugs may have additional restrictions, including diagnosis, quantity limit, and age limit restrictions.

The fall 2009 PDL will be implemented in two phases. Information about Phase I is included in this *Update*. A future *Update* will include more information about Phase II.

Preferred drugs are covered but may have restrictions. Non-preferred drugs may be covered with an approved prior authorization (PA). Noncovered drugs (e.g., drugs used for hair loss or other cosmetic purposes) are not covered, even with PA.

Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Most preferred drugs do not require PA, except in a limited number of classes (e.g., growth hormone drugs, cytokine and cell adhesion molecule [CAM] antagonist drugs).

Submitting Prior Authorization Requests

Prior authorization requests for non-preferred drugs for members enrolled in the Standard Plan, Medicaid, and SeniorCare may be submitted by pharmacy providers on the appropriate PA attachment form using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system, unless otherwise indicated.

As a reminder, if a PA request must be submitted on paper, prescribers are required to complete, sign, and date the appropriate PA attachment form and submit it, along with any supporting documentation, to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete, sign, and submit a Prior Authorization Request Form (PA/RF), F-11018 (10/08), and information on the PA attachment form to ForwardHealth.

Prior authorization requests for drugs listed in this *Update* should continue to be submitted by pharmacy providers, not prescribers. Prior authorization requests for drugs on the PDL will not be accepted through the Drug Authorization and Policy Override (DAPO) Center.

Phase I Changes for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare Members

Below are Phase I changes effective for DOS on and after October 1, 2009, for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

New Drug Classes

The Antihyperuricemics and Tetracyclines drug classes will be added to the PDL in Phase I.

Antifungals, Oral

Vfend® will be a non-preferred drug that requires PA. Members currently taking Vfend® will be grandfathered on the drug. Prior authorization is not required for a grandfathered drug. Other policies (e.g., diagnosis restrictions) for grandfathered drugs may apply.

Bronchodilators, Anticholinergic

Spiriva® continues to be a preferred drug; however, a diagnosis restriction has been added.

Pharmacy providers should submit claims for diagnosis-restricted drugs with the appropriate diagnosis code. The most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code must be indicated on claims for Spiriva®. One of the following allowable diagnosis codes must be indicated on claims for Spiriva® to be covered without PA.

Code	Description
491.0-491.9	Chronic bronchitis
492.0-492.8	Emphysema
493.2	Chronic obstructive asthma
496.0	Chronic airway obstruction, not elsewhere classified

When a claim is submitted with a missing or invalid diagnosis code, or with a code that is not an allowable diagnosis code, providers will receive Explanation of Benefits (EOB) code 510, which states "A valid Prior Authorization is required." If this EOB response is received because the provider did not submit an allowable diagnosis code, a paper PA request with supporting documentation should be submitted to ForwardHealth.

To request PA for Spiriva® for members who do not meet diagnosis restrictions, prescribers are required to complete the Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08), and submit the form with clinical documentation to the pharmacy where the prescription will be filled.

Cytokine and Cell Adhesion Molecule Antagonist Drugs

Cimzia®

Cimzia® will be a preferred drug that requires clinical PA. Prior authorization requests for Cimzia® may be submitted through the STAT-PA system on the current Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305 (10/08), or the current Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis, F-11308 (10/08).

Simponi™

Simponi™ is a non-preferred drug. Members are required to try and fail a preferred cytokine and CAM antagonist drug before PA may be requested for Simponi™. Prior authorization requests for Simponi™ must be submitted on paper by fax or mail with a PA/RF and the appropriate PA/PDL for cytokine and CAM antagonist drugs form. Prior authorization for Simponi™ cannot be obtained through the STAT-PA system.

Dipeptidyl Peptidase-4 Inhibitors

ForwardHealth has moved Januvia®, Janumet™, and Onglyza™ from the hypoglycemics, adjunct therapy drug class and created the dipeptidyl peptidase-4 (DPP-4) inhibitor drug class. Januvia® and Janumet™ continue to be preferred drugs.

More information about the hypoglycemics, adjunct therapy class is included below.

Glucocorticoids, Inhaled

Pulmicort® respules and budesonide respules will now be non-preferred drugs; however, PA will not be required for Pulmicort® respules and budesonide respules for members eight years of age and younger. Prior authorization will be required for Pulmicort® respules and budesonide respules for members 9 years of age and older.

Asmanex® remains a non-preferred drug; however, PA will not be required for Asmanex® 110 micrograms for members 12 years of age and younger. Prior authorization will be required for Asmanex® 110 micrograms for members 13 years of age and older and Asmanex® 220 micrograms for all members.

Hypoglycemics, Adjunct Therapy

Byetta® and Symlin® will be non-preferred drugs that continue to require clinical PA.

To request PA for Byetta® or Symlin®, prescribers are required to complete the Prior Authorization Drug Attachment for Byetta® and Symlin®, F-00080 (06/09), and submit the form to the pharmacy where the prescription will be filled. Prior authorization requests for Byetta® and Symlin® will no longer be accepted on the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy, F-11179 (01/09), on and after October 1, 2009.

Pharmacy providers may submit PA requests for Byetta® and Symlin® on the Portal or by fax or mail, *not* through the STAT-PA system.

ForwardHealth will make decisions on PA requests within 24 hours with the receipt of all the necessary information and fax or mail the decision to the provider who submitted the PA request. The decision may also be sent via the Portal.

Clinical Criteria

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.

Platelet Aggregation Inhibitors

Ticlopidine will be a non-preferred drug. Ticlopidine will be grandfathered indefinitely for members who are currently taking the drug. Prior authorization will be required for prescriptions for members who have not previously taken ticlopidine.

Ophthalmic, Glaucoma Agents

As a reminder, Lumigan® package sizes of 2.5 milliliters and 5 milliliters are preferred drugs. The Lumigan® 7.5 milliliter package size is a non-preferred drug that requires PA.

Stimulants and Related Agents

Before PA is requested for a non-preferred stimulant or related agent, the member is required to try and fail two preferred stimulants or related agents.

Strattera

Strattera® continues to be a non-preferred drug for members 18 years of age and younger. Strattera will be a non-preferred drug that requires PA for members 19 years of age and older. If a member is 19 years of age and older and currently taking Strattera®, the member will be grandfathered on the drug.

ForwardHealth has revised the PA/PDL for Stimulants and Related Agents, F-11097 (09/09). To request PA for Strattera®, prescribers are required to complete the PA/PDL for Stimulants and Related Agents and submit it to the pharmacy where the prescription will be filled. Pharmacy providers may submit PA requests for Strattera® using the STAT-PA system.

For PA requests received on and after October 1, 2009, ForwardHealth will not accept previous versions of the PA/PDL for Stimulants and Related Agents. Prior authorization requests submitted with an older version of the form will be returned to the provider unprocessed.

The following are new clinical criteria for Strattera®:

- The member has experienced treatment failures or clinically significant adverse drug reactions with two preferred stimulants.
- The member has a medical condition(s) (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant.
- The member has a medical history of substance abuse or misuse.
- The member has a serious risk of diversion.

Providers may refer to Attachments 1 and 2 of this *Update* for the revised PA/PDL for Stimulants and Related Agents completion instructions and form.

Provigil and Nuvigil

Provigil® and Nuvigil® continue to be non-preferred drugs.

Prior authorization requests for Provigil® and Nuvigil® for members enrolled in the Standard Plan, Medicaid, and SeniorCare should be submitted using the Prior Authorization Drug Attachment for Provigil® and Nuvigil®, F-00079 (09/09). This is a new form to request PA for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

The Prior Authorization Drug Attachment for Provigil® and Nuvigil® replaces the PA/PDL for Stimulants and Related Agents for PA requests submitted for Provigil® and Nuvigil®. ForwardHealth will no longer accept the PA/PDL for Stimulants and Related Agents for PA requests for Provigil® or Nuvigil®.

Pharmacy providers may submit PA requests for Provigil® and Nuvigil® on the Portal or by fax or mail. Requests for Provigil® and Nuvigil® cannot be submitted through the STAT-PA system.

Members are required to try and fail Provigil® before PA may be requested for Nuvigil®. A member must have tried and failed Provigil® *and* be diagnosed with either narcolepsy, obstructive sleep apnea/hypopnea syndrome (OSAHS), or shift work sleep disorder before PA may be requested for Nuvigil®.

ForwardHealth will make decisions on PA requests within 24 hours with the receipt of all the necessary information and fax or mail the decision to the provider who submitted the PA request. The decision may also be sent via the Portal.

Providers may refer to Attachments 3 and 4 for the PA/PDL for Provigil® and Nuvigil® completion instructions and form.

ForwardHealth has established quantity limits for Nuvigil®. ForwardHealth allows a maximum of 250 mg per day of Nuvigil®. As a reminder, ForwardHealth allows a maximum of 200 mg per day of Provigil®. Any dose that exceeds the quantity limit is a noncovered service. Providers should refer to the quantity limits data table on the Pharmacy page of the Portal for a list of drugs for which quantity limits apply.

Note: Diagnosis codes are no longer required on claims for Provigil® and Nuvigil®.

Clinical Criteria for Provigil® and Nuvigil®

Criteria for approval of a PA request for Provigil® and Nuvigil® 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 OSAHS:
  - ✓ The member has tried a continuous positive airway pressure 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 more than 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 Provigil® 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 two preferred stimulants or the member had a clinically significant adverse reaction.

Providers who are requesting PA for Nuvigil® should not complete Element 16 on the Prior Authorization Drug Attachment for Provigil® and Nuvigil®.

Quantity Limits

Effective for DOS on and after October 1, 2009, ForwardHealth has established quantity limits for glucagon kits and vials, EpiPens®, and EpiPen® Jr. Members will be allowed two glucagon kits or vials, two EpiPens®, or two EpiPen® Jrs per calendar month.

Providers may request an override of the quantity limit for glucagon kits and vials, EpiPens®, and EpiPen® Jr if the prescriber deems it is medically necessary. The pharmacy provider should contact the prescriber to determine whether or not it is medically necessary for the member to exceed the quantity limits.

If a larger quantity is deemed medically necessary by the prescriber, the pharmacy provider is required to complete the Noncompound Drug Claim, F-13072 (10/08), and a Pharmacy Special Handling Request, F-13074 (10/08), explaining the medical necessity to exceed the set quantity limits when EOB code 0485 ("Quantity limits exceeded") is received.

Emergency Medication Dispensing

ForwardHealth encourages pharmacy providers to dispense a 14-day emergency supply of a 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 with any type of restriction and the physician cannot be reached to obtain a new prescription or the appropriate documentation to override the restriction. Medications dispensed in an emergency do not require PA.

The emergency medication dispensing policy overrides drug restriction policies and all PA policies, including the PDL, brand medically necessary, and diagnosis-restricted drug policies. Policies such as member enrollment and noncovered services still apply for emergency medication dispensing.

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim with a Pharmacy Special Handling Request 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. Providers may also fax these forms to ForwardHealth at (608) 221-0885.

Phase I Changes for BadgerCare Plus Benchmark Plan and BadgerCare Plus Core Plan for Adults with No Dependent Children Members

Information below applies to members enrolled in the Core Plan effective for DOS on and after October 1, 2009. As a result of these changes, the BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference will be revised effective for DOS on and after October 1, 2009. The Quick Reference is posted to the Portal and providers should refer to it frequently for changes.

As a reminder, certain generic drugs that are non-preferred under the Standard Plan, Medicaid, or SeniorCare may be covered by the Benchmark Plan and the Core Plan (e.g., fentanyl transdermal patches). Providers may refer to the Pharmacy page of the Portal for the BadgerCare Plus Benchmark National Drug Code List and the BadgerCare Plus Core Plan National Drug Code List.

The Benchmark Plan covers a broad list of generic drugs and a limited number of over-the-counter drugs. The Benchmark Plan only covers drugs listed on the BadgerCare Plus Benchmark Plan National Drug Code List.

Bronchodilators, Anticholinergic

Spiriva® continues to be a preferred drug; however, a diagnosis restriction has been added.

Pharmacy providers should submit claims for diagnosis-restricted drugs with the appropriate diagnosis code. The most specific ICD-9-CM diagnosis code must be indicated on claims for Spiriva®. One of the following allowable diagnosis codes must be indicated on claims for Spiriva® to be covered without PA.

Code	Description
491.0-491.9	Chronic bronchitis
492.0-492.8	Emphysema
493.2	Chronic obstructive asthma
496.0	Chronic airway obstruction, not elsewhere classified

When a claim is submitted with a missing or invalid diagnosis code, or with a code that is not an allowable diagnosis code, providers will receive EOB code 510, which states "A valid Prior Authorization is required." If this EOB response is received because the provider did not submit an allowable diagnosis code, a paper PA request with supporting documentation should be submitted to ForwardHealth.

To request PA for Spiriva® for members who do not meet diagnosis restrictions, prescribers are required to complete the PA/DGA and submit the form with clinical documentation to the pharmacy where the prescription will be filled. Spiriva® is the only drug for Core Plan members for which PA is accepted with a diagnosis restriction.

Spiriva® is not covered by the Benchmark Plan.

Cytokine and Cell Adhesion Molecule Antagonist Drugs

Cimzia®

Cimzia® will be a preferred drug that requires clinical PA. Prior authorization requests for Cimzia® may be submitted on paper by fax or mail either on the current PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease or the current PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis. Prior authorization requests for Cimzia® for Core Plan members cannot be submitted using the STAT-PA system.

If a member does not meet the PA criteria for a cytokine or CAM antagonist drug, including Cimzia®, the drug is a noncovered service. Claims for Core Plan members who do not meet PA criteria for Cimzia® should be submitted to BadgerRx Gold.

Cimzia® is not covered by the Benchmark Plan.

Hypoglycemics, Adjunct Therapy

Members enrolled in the Core Plan who are currently taking Byetta® or Symlin® will be grandfathered on the drug for DOS from October 1, 2009, through September 30, 2010. Byetta® and Symlin® will be noncovered drugs for all other Core Plan members. Claims for Core Plan members who are not grandfathered on these drugs should be submitted to BadgerRx Gold.

Prior authorization cannot be requested for Byetta® or Symlin® for Core Plan members because Byetta® and Symlin® are non-preferred drugs.

Byetta® and Symlin® are not covered by the Benchmark Plan.

Platelet Aggregation Inhibitors

Ticlopidine will be a non-preferred drug. Ticlopidine will be grandfathered indefinitely for members who have previously taken the drug. Claims for Core Plan

members who are not grandfathered on ticlopidine should be submitted to BadgerRx Gold.

Ticlopidine will not be covered for members enrolled in the Benchmark Plan effective for DOS on and after October 1, 2009.

Stimulants and Related Agents

Strattera®

If a member is 19 years of age and older and is taking Strattera®, the member will be grandfathered on Strattera® until a generic equivalent becomes available.

Strattera® will not be covered for members who have not previously taken the drug. Prior authorization for Strattera® cannot be obtained for Core Plan members. Therefore, claims for Strattera® should be submitted to BadgerRx Gold.

Strattera® is not covered by the Benchmark Plan.

Provigil® and Nuvigil®

Prior authorization requests for Provigil® for Core Plan members should continue to be submitted on the Prior Authorization Drug Attachment for Provigil and Nuvigil.

Nuvigil® is a noncovered drug for members enrolled in the Core Plan. Claims for Nuvigil® for Core Plan members should be submitted to BadgerRx Gold.

Provigil® and Nuvigil® are not covered by the Benchmark Plan.

Quantity Limits

Effective for DOS on and after October 1, 2009, ForwardHealth has established quantity limits for glucagon kits and vials and EpiPens®. Members will be allowed two glucagon kits or vials or two EpiPens® per calendar month.

Providers may request an override of the quantity limit for glucagon kits and vials and EpiPens® if the prescriber deems it is medically necessary. The pharmacy provider should contact the prescriber to determine whether or not it is medically necessary for the member to exceed the quantity limits.

If a larger quantity is deemed medically necessary by the prescriber, the pharmacy provider is required to complete the Noncompound Drug Claim and a Pharmacy Special Handling Request explaining the medical necessity to exceed the set quantity limits when EOB code 0485 is received. Glucagon kits and vials and EpiPens® are the only drugs for Core Plan members for which the Noncompound Drug Claim may be submitted to request that a quantity limit be exceeded.

EpiPen® Jrs are not covered by the Core Plan.

Glucagon kits and vials, EpiPens®, and EpiPen® Jrs are not covered by the Benchmark Plan.

Grandfathering of Brand Name Drugs

As a reminder, if a Core Plan 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.

Emergency Medication Dispensing

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

- 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 with any type of restriction and the physician cannot be reached to obtain a new prescription or the appropriate documentation to override the restriction. 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 with a Pharmacy Special Handling Request 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. Providers may also fax these forms to ForwardHealth at (608) 221-0885.

There are no drugs covered by the Benchmark Plan that require PA; therefore, there is no emergency medication dispensing coverage for members enrolled in the Benchmark Plan.

Preferred Brand Name Drugs Excluded from Brand Medically Necessary Prior Authorization Requirements

When a drug first becomes available in a generic form, the generic price may be higher than the price of a brand name drug that has a substantial federal or supplemental rebate. Therefore, it is more cost-effective for ForwardHealth to reimburse providers for the brand name drug until the price of the generic drug becomes more competitive.

This policy applies to the Standard Plan, the Core Plan, Medicaid, and SeniorCare for drugs that are covered by the plans.

Brand Name Drugs for Which Generic Copayments Apply

Effective for DOS on and after October 1, 2009, pharmacy providers may indicate National Council for Prescription Drug Programs Dispense As Written (DAW) code "6" on claims for drugs excluded from brand medically necessary PA requirements.

Members pay the generic drug copayment, not the brand-name copayment, for drugs for which ForwardHealth has indicated that a preferred, brand name drug is less costly than its non-preferred generic counterpart and DAW code "6" is indicated on claims. Generic copayments apply to the following preferred brand name drugs:

- Adderall XR.
- Cosopt®.
- Famvir®.
- Miacalcin®.
- Ovide®.
- Trusopt®.

Note: Of the drugs previously listed, the Core Plan covers only Adderall XR.

Providers may refer to the PDL Quick Reference on the Portal for the complete list of preferred brand name drugs for which generic copayments apply and to the Online Handbook for more information about indicating DAW code "6" on claims for drugs excluded from brand medically necessary PA requirements.

Phase II Changes

Effective for DOS on and after November 16, 2009, changes will occur to the following drugs and drug classes:

- Antiemetics.
- Leukotriene modifiers.

- Nonsteroidal anti-inflammatory drugs.
- Suboxone® and Subutex®.
- Topical immunomodulators.

More information about changes to these drugs and drug classes will be published in a future service-specific *Update*.

ePocrates

ForwardHealth providers may access the PDL using their personal digital assistants (PDAs) or personal computers through ePocrates. ePocrates' products provide clinical reference information specifically for health care providers at the point of care. Prescribers and pharmacy providers who use PDAs may also subscribe and download the PDL by accessing the ePocrates Web site at *www.epocrates.com/*.

The Core Plan Brand Name Drug Quick Reference, which includes the Core Plan drug formulary, is available on the Portal and on the ePocrates Web site.

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 (MCO). 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/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions

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

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FORWARDHEALTH

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

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

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (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 PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and dispensing physicians are required to retain a completed copy of the form.

INSTRUCTIONS

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

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

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.

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

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

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

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

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 3 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

SECTION II — PRESCRIPTION INFORMATION

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

Element 4 — Drug Name
Enter the drug name.

Element 5 — Drug Strength
Enter the strength of the drug in Element 4.

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

Element 7 — Directions for Use
Enter the directions for use of the drug.

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI)
Enter the prescribing provider's NPI.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS

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

Element 12 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or the description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis for stimulants must be one of the approved stimulant diagnosis codes.

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS

Element 13
Check the appropriate box to indicate whether or not the member has experienced treatment failures or clinically significant adverse drug reactions with two preferred stimulants. If yes is checked, list the preferred stimulants, specific details about the treatment failures or adverse drug reactions, and the approximate dates the preferred drugs were taken.

SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA

Element 14
Check the appropriate box to indicate whether or not the member has experienced treatment failures or clinically significant adverse drug reactions with two preferred stimulants. If yes is checked, list the preferred stimulants, specific details about the treatment failures or adverse drug reactions, and the approximate dates the preferred drugs were taken.

Element 15
Check the appropriate box to indicate whether or not the member has a medical condition(s) (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant. If yes is checked, list the condition(s).

Element 16
Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse. If yes, explain in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has a serious risk of diversion. If yes, explain in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/PDL for Stimulants and Related Agents was signed (in MM/DD/CCYY format).

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply up to 365 days.

Element 22 — NPI
Enter the provider's NPI.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 24 — Patient Location
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

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

Element 25 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 27 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 28 — Number of Days Approved
Indicate the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 29
Indicate any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents

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

FORWARDHEALTH

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

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

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

SECTION I — MEMBER INFORMATION

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

SECTION II — PRESCRIPTION INFORMATION

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

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS

12. Diagnosis Code and Description

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS

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

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

SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA

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

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

Continued

SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA (Continued)

15. Does the member have a medical condition(s) (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant? ❑ Yes ❑ No

    If yes, list the medical condition(s) in the space below.

16. Does the member have a medical history of substance abuse or misuse? ❑ Yes ❑ No

    If yes, explain in the space below.

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

    If yes, explain in the space below.

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 Digits)	21. Days' Supply Requested (Up to 365 Days)

22. NPI

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

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

25. Assigned PA Number

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization Drug Attachment for Provigil® and Nuvigil® Completion Instructions

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

(This page was intentionally left blank.)

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR PROVIGIL® AND NUVIGIL® 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® and Nuvigil® 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).

Note: Nuvigil® is not covered by the BadgerCare Plus Core Plan for Adults with No Dependent Children.

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

Providers should check only the name and strength of the drug for which PA is being requested.

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

Element 5 — Nuvigil® 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 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 III — CLINICAL INFORMATION

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

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 is currently taking any other stimulants.

Element 16
For requests for Nuvigil®, indicate whether or not the member has tried and failed or had a significant adverse drug reaction to Provigil®. If yes is checked, provide the dose of Provigil® tried, the dates it was taken, and the reason(s) for discontinuation.

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY

Element 17
Indicate whether or not the member has a diagnosis of Narcolepsy.

Element 18
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 19
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 20
Indicate whether or not the member has a diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS).

Element 21
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 22
Indicate the member's Apnea-Hypopnea Index (AHI) in events per hour.

Element 23
Indicate whether or not the member has tried Continuous Positive Airway Pressure (CPAP).

SECTION III C — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

Element 24
Indicate whether or not the member has a diagnosis of shift work sleep disorder.

Element 25
Indicate whether or not the member is a night-shift worker.

Element 26
Indicate whether or not the member is taking any hypnotics, sleep aids, or other medications that can cause sleepiness.

Element 27
Enter the member's current employer, along with his or her weekly work schedule.

SECTION III D — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (PROVIGIL® ONLY)

Element 28
Indicate whether or not the member has a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).

Element 29
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 30
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 31
For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, indicate whether or not the member has experienced treatment failures or clinically significant adverse drug reactions with two or more preferred stimulants. If yes, list the stimulants tried, dates taken, and reasons for discontinuation.

Element 32
For members enrolled in the Core Plan, indicate whether or not the member has experienced treatment failures or clinically significant adverse drug reactions with two or more generic stimulants. If yes, list the stimulants tried, dates taken, and reasons for discontinuation.

SECTION IV — AUTHORIZED SIGNATURE

Element 33 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 34 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 35
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

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ATTACHMENT 4
Prior Authorization Drug Attachment for Provigil® and Nuvigil®

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00079 (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 PROVIGIL® AND NUVIGIL®

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

Nuvigil® is not covered for members enrolled in the BadgerCare Plus Core Plan for Adults with No Dependent Children.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number	3. Date of Birth

SECTION II — PRESCRIPTION INFORMATION

4. Provigil® Drug Strength (Check One)*	5. Nuvigil® Drug Strength (Check One)*
❑ 100 mg ❑ 200 mg	❑ 50 mg ❑ 150 mg ❑ 250 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 III — CLINICAL INFORMATION (Providers are required to complete Section III and either Section III A, III B, III C, or III D before signing this form.)

13. Diagnosis Code and Description

14. Is the member at least 16 years old?	❑ Yes	❑ No
15. Is the member taking any other stimulants?	❑ Yes	❑ No
16. For requests for Nuvigil®: Has the member tried and failed or had a significant adverse drug reaction to Provigil®? If yes, provide the dose of Provigil® tried, the dates it was taken, and the reason(s) for discontinuation in the space provided.	❑ Yes	❑ No

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY

17. Does the member have a diagnosis of Narcolepsy?	❑ Yes	❑ No
18. Has the member had a Polysomnogram (PSG)?	❑ Yes	❑ No
19. 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.

Continued

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

20. Does the member have a diagnosis of Obstructive Sleep Apnea / Hypopnea Syndrome (OSAHS)?	❑ Yes	❑ No
21. Has the member had a Polysomnogram (PSG)?	❑ Yes	❑ No
22. What is the member's Apnea-Hypopnea Index (AHI)?	_____ Events / Hour	
23. 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.

SECTION III C — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

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

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

SECTION III D — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (Provigil® Only)

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

If yes, explain in the space provided.

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

If yes, explain in the space provided.

31. For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare: Has the member experienced treatment failures or clinically significant adverse drug reactions with two or more preferred stimulants?	❑ Yes	❑ No

If yes, list the stimulants tried, dates taken, and the reasons for discontinuation.

32. For members enrolled in the Core Plan: Has the member experienced treatment failures or clinically significant adverse drug reactions with two or more generic stimulants?	❑ Yes	❑ No

If yes, list the stimulants tried, dates taken, and the reasons for discontinuation.

Continued

SECTION IV — AUTHORIZED SIGNATURE

33. **SIGNATURE** — Prescriber	34. Date Signed

SECTION V — ADDITIONAL INFORMATION

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

* Providers should check only *one* drug and one strength.

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.)

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.