

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 Phase II Changes

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about Phase II changes to the Preferred Drug List (PDL). Changes in Phase II are effective for dates of service on and after December 1, 2009.

Effective for dates of service (DOS) on and after December 1, 2009, Phase II of the fall 2009 Preferred Drug List (PDL) will be implemented by ForwardHealth. Providers should disregard the effective date of November 16, 2009, for Phase II of the fall PDL in the October 2009 *ForwardHealth Update* (2009-63), titled "Fall 2009 Preferred Drug List Review." Phase I of the fall 2009 PDL was implemented effective for DOS on and after October 1, 2009.

A future *ForwardHealth Update* will include information about changes to the glucocorticoids, inhaled and leukotriene modifiers drug classes and Suboxone and Subutex, which will be effective in January 2010.

Changes listed in this *Update* impact members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan for Adults with No Dependent Children, Medicaid, and SeniorCare. Changes are effective for DOS on and after December 1, 2009, unless otherwise indicated.

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

Providers should refer to the Wisconsin Medicaid, BadgerCare Plus, and SeniorCare Preferred Drug List — Quick Reference and the BadgerCare Plus Core Plan Brand Name Drugs — 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 preferred and non-preferred status.

Submitting Prior Authorization Requests

Prior authorization requests for drugs in classes in this *Update* may be submitted through the following:

- The Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system.
- On the Portal beginning December 14, 2009.
- On paper by fax or mail.

As a reminder, if a PA request is submitted on paper, prescribers are required to complete, sign, and date the appropriate PA 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), along with the PA form and supporting documentation submitted by the prescriber to ForwardHealth.

Antiemetics, Cannabinoids

ForwardHealth has divided the antiemetics drug class into two classes, the antiemetics drug class and the antiemetics, cannabinoids drug class. Providers may refer to the PDL Quick Reference for a list of the preferred and non-preferred drugs in these two classes.

Antiemetics, cannabinoid drugs are not covered by the Benchmark Plan or the Core Plan.

Prior Authorization

Prior authorization is required for all antiemetic, cannabinoid drugs. To request PA, prescribers are required to complete and submit the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids, F-00194 (11/09), to the pharmacy where the prescription will be filled.

Prior authorization requests for antiemetic, cannabinoid drugs will be approved for a maximum of 183 days per request.

Current, approved PAs for drugs in this class will be honored until their expiration date.

Providers may begin submitting PA requests for antiemetics and antiemetic, cannabinoid drugs through the STAT-PA system or by fax or mail beginning December 1, 2009. Prior authorization requests may be submitted on the Portal using the PA/PDL for Antiemetics, Cannabinoids beginning December 14, 2009.

Refer to Attachments 1 and 2 of this *Update* for the PA/PDL for Antiemetics, Cannabinoids completion instructions and form.

Marinol

For DOS on and after December 1, 2009, Marinol will change from a non-preferred drug to a preferred, brand name drug that is excluded from brand medically necessary PA requirements. Pharmacy providers may indicate National Council for Prescription Drug Programs (NCPDP) 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.

Dronabinol

Dronabinol, the generic of Marinol, is a non-preferred antiemetic, cannabinoid drug that requires PA. Prior authorization requests for dronabinol may be submitted on the Portal beginning December 14, 2009, or on paper by fax or mail on the PA/PDL for Antiemetics, Cannabinoids form. Prior authorization requests for dronabinol cannot be submitted using the STAT-PA system.

For PA requests for dronabinol, members must meet the same clinical criteria as Marinol, which is listed below. Prescribers are required to indicate on the PA/PDL for Antiemetics, Cannabinoids form documentation that clinically justifies the need for the generic equivalent drug instead of Marinol.

Clinical Criteria

Members who are prescribed Marinol for the treatment of appetite/weight loss caused by human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) are not required to have previously tried ondansetron or Emend®.

Members are required to experience a treatment failure, an adverse drug reaction, or a contraindication with

ondansetron and Emend® and trial *and* failure of Marinol before a PA request may be submitted for Cesamet.

Clinical criteria for the approval of a PA request for antiemetic, cannabinoid drugs are the following:

- The member is currently receiving chemotherapy treatment for cancer. (For Marinol and Cesamet.)
- The member has experienced a treatment failure, adverse drug reaction, or contraindication with ondansetron and Emend for chemotherapy-related nausea and vomiting. (For Marinol and Cesamet.)
- The member has experienced a treatment failure with Marinol for chemotherapy-related nausea and vomiting. (For Cesamet only.)
- The member is diagnosed with appetite/weight loss caused by HIV or AIDS. (For Marinol only.)

Elidel® and Protopic®

Elidel® and Protopic® continue to be non-preferred drugs that require PA. Allowable diagnosis codes must be indicated on PA requests for Elidel® and Protopic®. Allowable diagnosis codes for Elidel® and Protopic® are 691.0 (diaper or napkin rash) or 691.8 (other atopic dermatitis and related conditions).

ForwardHealth has revised the clinical criteria for Elidel® and Protopic®. Clinical criteria for approval of a PA request for Elidel® and Protopic® are the following:

- The prescription is written by a dermatologist or allergist or through a dermatology or allergy consultation.
- The member is not immunocompromised.
- The member has not taken an antiretroviral or antineoplastic drug in the past two years.
- The member has experienced a treatment failure or a clinically significant adverse drug reaction to a topical corticosteroid in the past 183 days or the member has received treatment with Elidel® or Protopic® in the past 183 days and achieved a measureable therapeutic response.

Members must be at least 16 years of age or older to receive Protopic® 0.1 percent. Members must be at least two years of age or older to receive Protopic® 0.03 percent or Elidel®.

Prescribers are required to attest on the PA/PDL for Elidel® and Protopic® form to having discussed the potential risks and warnings of prescribing Elidel® or Protopic® for members under two years of age with the member's parent or guardian.

Note: If the prescriber determines that Elidel® or Protopic® 0.03 percent is medically necessary for a member under two years of age, PA requests for the drug may be approved if the prescriber attests on the PA/PDL for Elidel® and Protopic® to discussing the potential risks and warnings of using the products on children under two years of age. Prior authorization requests submitted when a prescriber determines that Elidel® or Protopic® 0.03 percent is medically necessary for a member under two years of age must be submitted on paper by mail or fax. Prior authorization requests cannot be submitted using the STAT-PA system or on the Portal.

As a result of the revised clinical criteria for Elidel® and Protopic®, ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Elidel® and Protopic®, F-11303 (11/09). Providers may refer to Attachments 3 and 4 for the revised completion instructions and form. Prior authorization requests received by ForwardHealth on and after December 1, 2009, with the PA/PDL for Elidel® and Protopic® dated October 2008 will be returned to providers unprocessed.

Prior authorization requests for Elidel® or Protopic® may be approved for a maximum of 183 days per request.

Providers may begin submitting PA requests for Elidel® and Protopic® through the STAT-PA system or by fax or mail beginning December 1, 2009. Prior authorization requests may be submitted on the Portal using the

PA/PDL for Elidel® and Protopic® beginning December 14, 2009.

Current, approved PAs for drugs in this class will be honored until their expiration date.

Elidel® and Protopic® are not covered by the Benchmark Plan or the Core Plan.

Nonsteroidal Anti-Inflammatory Drugs, Including Cyclo-oxygenase Inhibitors

ForwardHealth has revised the clinical criteria for NSAIDs, including cyclo-oxygenase inhibitors. For non-preferred NSAIDs, including cyclo-oxygenase inhibitors and Celebrex, the clinical criteria is that the member has tried and failed two preferred, generic NSAIDs or had an adverse drug reaction. (The two preferred, generic NSAIDs taken cannot be ibuprofen or naproxen.)

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

- The member has a history of familial adenomatous polyposis (FAP).
- The member has medical record documentation of thrombocytopenia or platelet dysfunction.
- The member has medical record documentation of peptic ulcer disease, history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding.
- The member is currently taking oral anticoagulation therapy.
- The member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.
- The member is 65 years of age or older.

As a result of the revised clinical criteria, ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs Including Cyclo-Oxygenase Inhibitors, F-11077 (11/09). Providers may refer to Attachments 5 and 6 for the revised completion instructions and forms. Prior

authorization requests received by ForwardHealth on and after December 1, 2009, with the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, dated January 2009 will be returned to providers unprocessed.

Providers may begin submitting PA requests for NSAIDs, including cyclo-oxygenase inhibitors and Celebrex, through the STAT-PA system or by fax or mail beginning December 1, 2009. Prior authorization requests may be submitted on the Portal using the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, beginning December 14, 2009.

Current, approved PAs for drugs in this class will be honored until their expiration date.

Providers may refer to the BadgerCare Plus Benchmark Plan National Drug Code List and the BadgerCare Plus Core Plan National Drug Code List on the Pharmacy page of the Portal for a current list of covered drugs for members enrolled in the Benchmark Plan and the Core Plan.

Phase I Prior Authorization Forms Available on the ForwardHealth Portal

The following fall 2009 PDL Phase I PA forms are now available for providers to complete and submit PA requests using the Portal:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents, F-11097 (09/09).
- The Prior Authorization Drug Attachment for Provigil® and Nuvigil®, F-00079 (09/09).
- The Prior Authorization Drug Attachment for Byetta and Symlin, F-00080 (06/09).

Prior authorization requests for these drugs may be submitted via the Portal immediately.

Grandfathering of Brand Name Drugs

Effective for DOS on and after January 1, 2010, if a Standard Plan, Medicaid, or SeniorCare member is

grandfathered on a brand name drug and a generic equivalent is available or will become available, grandfathering of the brand name drug for the member will be discontinued when the brand name drug is added to the Brand Medically Necessary Drugs That Require Prior Authorization data table on the Pharmacy page of the Portal. The data table is revised monthly.

This policy applies to brand name drugs where a generic equivalent is currently available *and* brand name drugs where a generic equivalent will be released in the future.

Providers should submit a PA request for brand name drugs for the member to continue taking the drug. To request PA for a brand name drug, prescribers are required to complete and submit to the pharmacy provider the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083 (10/08), the prescription with “Brand Medically Necessary” handwritten on it, and all of the appropriate supporting documentation. The pharmacy provider completes a PA/RF and submits to ForwardHealth the following:

- A completed PA/BMNA from the prescriber.
- Supporting documentation submitted by the prescriber. (The PA request must include sufficient supporting documentation for a pharmacist consultant to make a determination about the request.)
- A copy of the prescription with “Brand Medically Necessary” handwritten by the prescriber.
- A completed PA/RF.

In most circumstances, it will be necessary for a member to try more than one generic equivalent drug before a brand medically necessary PA request may be approved. If a generic equivalent drug is a non-preferred drug on the PDL, the member must try and fail preferred, generic drugs before a brand medically necessary PA request may be approved.

Documentation Requirements

Supporting documentation should include how the generic equivalent drug failed to achieve the desired treatment outcome and why the brand name drug is expected to achieved the desired outcome.

Prescribers should document on the PA request the specific details about the previous treatment results with generic equivalent drugs, including the generic equivalent drugs that the member tried.

Grandfathering Brand Name Drugs for Core Plan Members

As a reminder, if a Core Plan member is currently grandfathered on a brand name drug and a generic equivalent becomes available, grandfathering of the brand name drug for the member will be discontinued.

Providers may refer to the topic titled “Core Plan Pharmacy Services Exceptions for Transitioned Members” in the Pharmacy service area of the ForwardHealth Online Handbook on the Portal for information about brand medically necessary PA for grandfathered transitioned members.

Revised Emergency Medication Dispensing Policy

ForwardHealth strongly encourages pharmacy providers to dispense a 14-day emergency supply of a medication when a member receives a prescription for a covered drug with a PA restriction and the physician cannot be reached to obtain a new prescription or the appropriate documentation to override the PA restriction. Medications dispensed in an emergency do not require PA.

Effective for DOS on and after January 1, 2010, providers may dispense up to two consecutive 14-day emergency supplies of a drug while a PA request is under review. For members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare, pharmacy providers are required to call Provider Services at (800)

947-9627 to obtain a policy override to exceed dispensing two consecutive emergency supplies of a drug.

This emergency medication dispensing policy applies to members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare.

Note: For Core Plan members, the only diagnosis-restricted drugs for which ForwardHealth accepts PA requests is Spiriva®.

The emergency medication dispensing policy overrides all PA policies, including the PDL, brand medically necessary, clinical PA, and diagnosis-restricted drug policies. However, other policies such as member enrollment, noncovered services, and age and gender restrictions still apply.

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim, F-13072 (10/08), with a Pharmacy Special Handling Request, F-13074 (10/08), indicating the nature of the emergency. Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request form. Providers may also fax these forms to ForwardHealth at (608) 221-0885.

Providers may refer to the Online Handbook for information about the emergency medication dispensing policy for members enrolled in the Core Plan.

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.

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 Antiemetics, Cannabinoids Completion
Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Antiemetics, Cannabinoids Completion Instructions" is located on the following pages.)

FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTIEMETICS, CANNABINOIDS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information applies to Medicaid and SeniorCare.

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 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 items. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids, F-00194. Pharmacy providers are required to use the PA/PDL for Antiemetics, Cannabinoids to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

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

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

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

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

Element 2 — 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.

SECTION II — PRESCRIPTION INFORMATION

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

Element 4 — Drug Name

Enter the drug name.

Element 5 — Drug Strength

Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written

Enter the date the prescription was written.

Element 7 — Directions for Use

Enter the directions for use of the drug.

Element 8 — Name — Prescriber

Enter the name of the prescriber.

Element 9 — National Provider Identifier — Prescriber

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

Element 10 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for Antiemetics, Cannabinoids form.

For PA requests for dronabinol, providers are required to complete Section III, Section III A or Section III B, and Section VI on the PA/PDL for Antiemetics, Cannabinoids form and submit the request to ForwardHealth on the ForwardHealth Portal or on paper by mail or fax. Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol. Additional documentation should be included in Section VI or submitted as an attachment.

Element 12 — Diagnosis Code and Description

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

SECTION III A — CLINICAL INFORMATION FOR MARINOL ONLY

Element 13

Check the appropriate box to indicate whether or not the member has been diagnosed with a loss of appetite/weight loss caused by Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome. If yes, providers do not need to complete Section III B.

SECTION III B — CLINICAL INFORMATION FOR MARINOL AND CESAMET

Element 14

Check the appropriate box to indicate whether or not the member has experienced a treatment failure with ondansetron for chemotherapy-related nausea and vomiting.

Element 15

Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of ondansetron. If yes, list the medical condition(s) that prevents the use of ondansetron in the space provided.

Element 16

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and ondansetron. If yes, describe the clinically significant drug interaction in the space provided.

F-00194A (11/09)

Element 17

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction while taking ondansetron. If yes, describe the clinically significant adverse drug reaction in the space provided.

Element 18

Check the appropriate box to indicate whether or not the member has experienced a treatment failure with Emend for chemotherapy-related nausea and vomiting.

Element 19

Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of Emend. If yes, list the medical condition(s) that prevents the use of Emend in the space provided.

Element 20

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Emend. If yes, describe the clinically significant drug interaction in the space provided.

Element 21

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction while taking Emend. If yes, describe the clinically significant adverse drug reaction in the space provided.

SECTION III C — CLINICAL INFORMATION FOR CESAMET ONLY

For PA requests for Cesamet, providers should complete Section III B and Section III C.

Element 22

Check the appropriate box to indicate whether or not the member has experienced a treatment failure with Marinol for chemotherapy-related nausea and vomiting.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 23 — National Drug Code

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

Element 24 — Days' Supply Requested

Enter the requested days' supply.

Note: ForwardHealth will not approve a days' supply greater than 183 days.

Element 25 — National Provider Identifier

Enter the NPI of the pharmacy provider.

Element 26 — Date of Service

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

Element 27 — Patient Location

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

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

Element 28 — Assigned PA Number

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

Element 29 — Grant Date

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

Element 30 — Expiration Date

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

Element 31 — Number of Days Approved

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

SECTION V — AUTHORIZED SIGNATURE

Element 32 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 33 — Date Signed

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

SECTION VI — ADDITIONAL INFORMATION

Element 34

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

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL)
for Antiemetics, Cannabinoids

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Antiemetics, Cannabinoids" is located on the following pages.)

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR ANTIEMETICS, CANNABINOIDS**

Instructions: Print or type clearly. Refer to the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids Completion Instructions, F-00194A, for more information.

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

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth — Member

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 — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (For PA requests for dronabinol, providers are required to complete Section III, Section III A or Section III B, and Section VI of this form and submit the request to ForwardHealth on the ForwardHealth Portal or on paper by mail or fax. Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol. Additional documentation should be included in Section VI or submitted as an attachment.)

12. Diagnosis Code and Description

SECTION III A — CLINICAL INFORMATION FOR MARINOL ONLY

13. Has the member been diagnosed with a loss of appetite/weight loss caused by Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome?

Yes

No

SECTION III B — CLINICAL INFORMATION FOR MARINOL AND CESAMET

14. Has the member experienced a treatment failure with ondansetron for chemotherapy-related nausea and vomiting?

Yes

No

15. Does the member have a medical condition(s) preventing the use of ondansetron?

Yes

No

If yes, list the medical condition(s) that prevents the use of ondansetron in the space provided.

Continued

BARCODE GOES HERE

SECTION III B — CLINICAL INFORMATION FOR MARINOL AND CESAMET (Continued)

16. Is there a clinically significant drug interaction between another medication the member is taking and ondansetron? Yes No

If yes, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

17. Has the member experienced a clinically significant adverse drug reaction while taking ondansetron? Yes No

If yes, describe the clinically significant adverse drug reaction in the space provided.

18. Has the member experienced a treatment failure with Emend for chemotherapy-related nausea and vomiting? Yes No

19. Does the member have a medical condition(s) preventing the use of Emend? Yes No

If yes, list the medical condition(s) that prevents the use of Emend in the space provided.

20. Is there a clinically significant drug interaction between another medication the member is taking and Emend? Yes No

If yes, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

21. Has the member experienced a clinically significant adverse drug reaction while taking Emend? Yes No

If yes, describe the clinically significant adverse drug reaction the space provided.

SECTION III C — CLINICAL INFORMATION FOR CESAMET ONLY (Complete Section III B and Section III C for requests for Cesamet.)

22. Has the member experienced a treatment failure with Marinol for chemotherapy-related nausea and vomiting? Yes No

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 183 Days)
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25. National Provider Identifier

26. 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.)

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

28. Assigned PA Number

29. Grant Date	30. Expiration Date	31. Number of Days Approved
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SECTION V — AUTHORIZED SIGNATURE

32. **SIGNATURE** — Prescriber

33. Date Signed

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL)
for Elidel[®] and Protopic[®] Completion Instructions

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

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR ELIDEL[®] AND PROTOPIC[®] COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information applies to Medicaid and SeniorCare.

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 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 items. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Elidel[®] and Protopic[®], F-11303. Pharmacy providers are required to use the PA/PDL for Elidel[®] and Protopic[®] to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

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

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

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

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

Element 2 — 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.

SECTION II — PRESCRIPTION INFORMATION

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

Element 4 — Drug Name

Enter the drug name.

Element 5 — Drug Strength

Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written

Enter the date the prescription was written.

Element 7 — Directions for Use

Enter the directions for use of the drug.

Element 8 — Name — Prescriber

Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber

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

Element 10 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Providers are required to complete all sections before signing and dating the PA/PDL for Elidel[®] and Protopic[®] form.

Element 12 — Diagnosis Code and Description

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

Element 13

Check the appropriate box to indicate whether or not the member is younger than two years of age. If yes, providers are required to submit the PA request to ForwardHealth on paper by fax or mail.

If the member is younger than two years of age, the prescriber must attest by signing this form to having discussed the potential risks and warnings of prescribing Elidel[®] or Protopic[®] with the member's family or guardian. Elidel[®] and Protopic[®] are not approved by the Food and Drug Administration for children younger than two years of age.

Element 14

Check the appropriate box to indicate whether or not the prescription for Elidel[®] or Protopic[®] was written by a dermatologist or an allergist or through a dermatology or allergy consultation.

Element 15

Check the appropriate box to indicate whether or not the member is immunocompromised.

Element 16

Check the appropriate box to indicate whether or not the member has taken an antiretroviral or antineoplastic agent within the past two years.

Element 17

Check the appropriate box to indicate whether or not the member has experienced a treatment failure or a clinically significant adverse drug reaction with a topical corticosteroid in the past 183 days. If yes, indicate in the space provided the topical corticosteroid that the member experienced a treatment failure(s) on, the specific details about the treatment failure(s), and the approximate date(s) the topical corticosteroid was taken.

Element 18

Check the appropriate box to indicate whether or not the member has received treatment with Elidel[®] or Protopic[®] in the last 183 days and achieved a measurable therapeutic response.

SECTION IV — AUTHORIZED SIGNATURE

Element 19 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 20 — Date Signed

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

Element 21 — National Drug Code

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

Element 22 — Days' Supply Requested

Enter the requested days' supply.

Note: ForwardHealth will not approve a days' supply greater than 183 days.

Element 23 — National Provider Identifier

Enter the NPI of the pharmacy provider.

Element 24 — Date of Service

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

Element 25 — Patient Location

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

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

Element 26 — Assigned PA Number

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

Element 27 — Grant Date

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

Element 28 — Expiration Date

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

Element 29 — Number of Days Approved

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

SECTION VI — ADDITIONAL INFORMATION

Element 30

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

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL)
for Elidel[®] and Protopic[®]

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

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR ELIDEL[®] AND PROTOPIC[®]**

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Elidel[®] and Protopic[®] Completion Instructions, F-11303A.

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

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth — Member

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) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

12. Diagnosis Code and Description

13. Is the member younger than two years of age?

Yes

No

If yes, the prescriber attests by signing below to having discussed the potential risks and warnings of prescribing Elidel[®] or Protopic[®] with the member's parent or guardian. Elidel[®] and Protopic[®] are not approved by the Food and Drug Administration for children younger than two years of age.

SIGNATURE — Prescriber

Date Signed

14. Is the prescription for Elidel or Protopic written by a dermatologist or an allergist or through a dermatology or allergy consultation?

Yes

No

15. Is the member immunocompromised?

Yes

No

16. Has the member taken an antiretroviral or antineoplastic agent within the past two years?

Yes

No

Continued



SECTION III — CLINICAL INFORMATION (Continued)

17. Has the member experienced a treatment failure or a clinically significant adverse drug reaction to a topical corticosteroid in the past 183 days? Yes No

If yes, list the topical corticosteroid and the approximate dates taken in the space provided.

-
18. Has the member received treatment with Elidel[®] or Protopic[®] in the past 183 days and achieved a measurable therapeutic response? Yes No
-

SECTION IV — AUTHORIZED SIGNATURE

19. **SIGNATURE** — Prescriber

20. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 Digits)

22. Days' Supply Requested (Up to 183 Days)

23. National Provider Identifier

24. 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.)

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

26. Assigned PA Number

27. Grant Date

28. Expiration Date

29. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL)
for Non-Steroidal Anti-Inflammatory Drugs
(NSAIDs), Including Cyclo-oxygenase Inhibitors
Completion Instructions

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

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

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information applies to Medicaid and SeniorCare.

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. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

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

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

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

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

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

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

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

Element 2 — 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.

SECTION II — PRESCRIPTION INFORMATION

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

Element 4 — Drug Name

Enter the drug name.

Element 5 — Drug Strength

Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written

Enter the date the prescription was written.

Element 7 — Directions for Use

Enter the directions for use of the drug.

Element 8 — Name — Prescriber

Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber

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

Element 10 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form. Complete Section IIIA for PA requests for NSAIDs including cyclo-oxygenase inhibitors or Section III B for PA requests for cyclo-oxygenase inhibitors only.

Element 12 — Diagnosis Code and Description

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

SECTION III A — CLINICAL INFORMATION FOR NONSTEROIDAL ANTI-INFLAMMATORY DRUGS, INCLUDING CYCLO-OXYGENASE INHIBITORS

Element 13

Check the appropriate box to indicate whether or not the member has tried and failed two preferred, generic NSAIDs or experienced an adverse drug reaction. (The two preferred, generic NSAIDs taken cannot include ibuprofen or naproxen.) If yes, check the boxes to indicate the two NSAIDs that were taken and list the specific details about the treatment failures or adverse drug reactions and the approximate dates the two preferred, generic NSAIDs were taken in the space provided.

SECTION III B — CLINICAL INFORMATION FOR CYCLO-OXYGENASE INHIBITORS ONLY

Element 14

Check the appropriate box to indicate if the member has a history of familial adenomatous polyposis (FAP).

Element 15

Check the appropriate box to indicate if the member has medical record documentation of thrombocytopenia or platelet dysfunction.

Element 16

Check the appropriate box to indicate if the member has medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding.

Element 17

Check the appropriate box to indicate if the member is currently taking oral anticoagulation therapy.

Element 18

Check the appropriate box to indicate if the member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.

Element 19

Check the appropriate box to indicate if the member is 65 years of age or older.

SECTION VI — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code

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

Element 21 — Days' Supply Requested

Enter the requested days' supply.

Element 22 — National Provider Identifier

Enter the NPI of the pharmacy provider.

Element 23 — Date of Service

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

Element 24 — Patient Location

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

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

Element 25 — Assigned PA Number

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 STAT-PA request was approved by the STAT-PA system.

SECTION V — AUTHORIZED SIGNATURE

Element 29 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 30 — Date Signed

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

SECTION VI — ADDITIONAL INFORMATION

Element 31

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

ATTACHMENT 6
Prior Authorization/Preferred Drug List (PA/PDL)
for Non-Steroidal Anti-Inflammatory Drugs
(NSAIDs), Including Cyclo-oxygenase Inhibitors

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

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

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

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

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth — Member

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) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Complete Section III A or Section III B.)

12. Diagnosis Code and Description

**SECTION III A — CLINICAL INFORMATION FOR NONSTEROIDAL ANTI-INFLAMMATORY DRUGS, INCLUDING CYCLO-
OXYGENASE INHIBITORS**

13. Has the member tried and failed two preferred, generic NSAIDs or experienced an adverse drug reaction? (The two preferred, generic NSAIDs taken cannot include ibuprofen or naproxen.) Yes No

If yes, check the two preferred, generic NSAIDs that were taken.

1. diclofenac
2. flurbiprofen
3. indomethacin
4. ketoprofen
5. ketorolac
6. meclofenamate
7. meloxicam
8. nabumetone
9. piroxicam

List the specific details about the treatment failures or adverse drug reactions and the approximate dates the two preferred, generic NSAIDs were taken in the space provided.

Continued



DT-PA039-039

SECTION III B — CLINICAL INFORMATION FOR CYCLO-OXYGENASE INHIBITORS ONLY

- | | | |
|--|------------------------------|-----------------------------|
| 14. Does the member have a history of familial adenomatous polyposis (FAP)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Does the member have medical record documentation of thrombocytopenia or platelet dysfunction? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Does the member have medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Is the member currently taking oral anticoagulation therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Has the member been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Is the member 65 years of age or older? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

- | | | |
|---|---|-----------------------------|
| 20. National Drug Code (11 Digits) | 21. Days' Supply Requested (Up to 365 Days) | |
| 22. National Provider Identifier | | |
| 23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.) | | |
| 24. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].) | | |
| 25. Assigned PA Number | | |
| 26. Grant Date | 27. Expiration Date | 28. Number of Days Approved |

SECTION V — AUTHORIZED SIGNATURE

- | | |
|----------------------------|-----------------|
| 29. SIGNATURE — Prescriber | 30. Date Signed |
|----------------------------|-----------------|

SECTION VI — ADDITIONAL INFORMATION

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