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, Individual Medical Supply Providers, Medical Equipment Vendors, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Changes to Pharmacy Policies Occurring in December 2010

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to pharmacy policies and reminders about other pharmacy policy changes effective for dates of service on and after December 1, 2010, unless otherwise noted.

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to pharmacy policies and reminders about other pharmacy policy changes effective for dates of service (DOS) on and after December 1, 2010, unless otherwise noted.

For information about covered drugs, providers may refer to the following benefit plan-specific pharmacy data tables on the Pharmacy page in the Providers area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/*:

- Wisconsin Medicaid, BadgerCare Plus Standard, and SeniorCare Preferred Drug List — Quick Reference.
- BadgerCare Plus Core Plan National Drug Code List.
- BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference.
- BadgerCare Plus Benchmark Plan National Drug Code List.
- BadgerCare Plus Basic Plan National Drug Code List.

Prescriber Responsibilities for Prior Authorization for Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical prior authorization (PA) is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate PA form and submit it to the pharmacy where the prescription will be filled. Prescribers are required to include accurate and complete answers and clinical information about the member's medical history on the PA form. When completing the PA form, prescribers are required to provide a handwritten signature and date on the form. Prior authorization request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers should not submit PA forms to ForwardHealth.

Prescribers are required to retain a completed copy of the PA form.

For Benchmark Plan, Core Plan, and Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the

plan. Providers may refer to the previously listed benefit plan-specific resources on the Portal for a list of drugs covered by each benefit plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Pharmacy Provider Responsibilities for Prior Authorization for Drugs

Pharmacy providers should review the Wisconsin Medicaid, BadgerCare Plus Standard, and SeniorCare Preferred Drug List — Quick Reference on the Pharmacy page in the Providers area of the Portal for the most current list of preferred and non-preferred drugs. Most preferred drugs do not require PA, but may have other restrictions (e.g., age, diagnosis).

If a member presents a prescription for a non-preferred drug, the pharmacy provider is encouraged to contact the prescriber to discuss preferred drug options. The prescriber may choose to change the prescription to a preferred drug, if medically appropriate for the member, or the prescriber may complete the appropriate PA form.

Pharmacies are required to submit the PA request using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or on paper by fax or mail.

Pharmacy providers are required to retain a completed copy of the PA form.

For Benchmark Plan, Core Plan, and Basic Plan members, pharmacy providers should be aware of drugs covered by the benefit plan. Providers may refer to the previously listed benefit plan-specific resources on the Portal for a list of drugs covered by each benefit plan.

For Benchmark Plan, Core Plan, and Basic Plan members, if a drug is a noncovered drug or PA cannot be obtained for the drug, claims for the drug may be submitted to BadgerRx Gold.

Angiotensin Modulators

ForwardHealth has separated the angiotensin modulators drug class into the following classes:

- Angiotensin modulators, ACE inhibitors.
- Angiotensin modulators, ARBs and DRIs.
- Angiotensin modulator combinations.

Members must meet PA criteria for drugs in the respective angiotensin modulators drug class before a PA request may be submitted for a non-preferred drug in the class.

Pharmacy providers should begin working with prescribers to either switch a member's prescription to a preferred drug in the angiotensin modulators drug classes or request PA for a non-preferred drug if it is medically appropriate for the member. Prior authorization requests for non-preferred drugs should be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/08).

Losartan

Losartan and losartan HCTZ will be the only preferred drugs in the angiotensin modulators, ARBs and DRIs drug class. In addition, a quantity limit will no longer apply to losartan. Instead, losartan and losartan HCTZ will be added to the list of drugs for which pharmacy providers are required to dispense a three-month supply. Providers may refer to the Three-Month Supply Drugs data table on the Pharmacy page in the Providers area of the ForwardHealth Portal for a complete list of drugs pharmacy providers are required to dispense in a three-month supply. For more information about the three-month supply policy, providers may refer to the Online Handbook on the Portal.

Losartan and losartan HCTZ continue to be covered for Standard Plan, Benchmark Plan, Core Plan, Basic Plan, Medicaid, and SeniorCare members.

Note: Providers should be aware that Diovan®, Diovian/HCTZ®, Micardis®, and Micardis HCTZ® will be non-preferred drugs that require PA on and after January 1, 2011.

Anticoagulants, Injectables

The anticoagulants, injectables drug class will be renamed the antithrombotic agents, injectable drug class.

Antihyperurecemics, Oral

The antihyperurecemics drug class will be renamed the gout agents drug class.

Since indomethacin and federal legend naproxen are preferred, nonsteroidal anti-inflammatory drugs (NSAIDs) that are effective anti-inflammatory agents for treating acute gout, they will be added to the gout agents drug class. Indomethacin and federal legend naproxen will be listed as preferred drugs in both the NSAIDs drug class and the gout agents drug class.

Allopurinol, probenecid, and probenecid/colchicine continue to be preferred drugs in the gout agents drug class.

Colcrys® continues to be a non-preferred drug with quantity limits for Standard Plan, Medicaid, and SeniorCare members.

Antifungals, Topical

As a reminder, ketoconazole cream will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Ketoconazole cream will be a noncovered drug for members in the Benchmark Plan, the Core Plan, and the Basic Plan.

Over-the-counter (OTC) terbinafine products will be noncovered drugs for Standard Plan, Benchmark Plan, Core Plan, Basic Plan, and Medicaid members.

Anti-Obesity Drugs

Meridia® was removed from the market as a result of an Food and Drug Administration (FDA) safety recommendation about cardiovascular risks. Effective for DOS on and after November 1, 2010, Meridia® is no longer covered.

As a result of changes to the drug class, ForwardHealth has revised the Prior Authorization Drug Attachment for Anti-Obesity Drugs, F-00163 (11/10). Providers may refer to Attachments 1 and 2 of this *Update* for the revised completion instructions and form.

Clinical Criteria

As a result of the removal of Meridia® from the market, PA criteria for anti-obesity drugs have been revised.

Clinical criteria for approval of a PA request for anti-obesity drugs require one of the following:

- The member has a body mass index (BMI) greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 *and* two or more of the following risk factors:
  - ✓ Coronary heart disease.
  - ✓ Dyslipidemia.
  - ✓ Hypertension.
  - ✓ Sleep apnea.
  - ✓ Type II diabetes mellitus.

In addition, all of the following must be true:

- The member is 16 years of age or older. (*Note:* Members need only to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The member does not have a medical contraindication to the selected medication.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

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

Note: ForwardHealth does not cover the brand name (i.e., innovator) anti-obesity drug if an FDA-approved generic equivalent is available. In addition, ForwardHealth does not cover OTC anti-obesity drugs.

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

Benzphetamine, Diethylpropion, Phendimetrazine, and Phentermine

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

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

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

Xenical®

If clinical criteria for anti-obesity drugs are met, initial PA requests for Xenical® (orlistat) will be approved for six months. If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, the member must wait six months before PA is requested for any anti-obesity drug. If the member meets a weight loss goal of at least 10 pounds during the first six months of treatment, PA may be requested for an additional six months of treatment. If the member continues to lose weight, subsequent PA renewal periods for Xenical® are a maximum of six months.

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

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

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

Antithrombotic Agents, Oral

The antithrombotic agents, oral drug class will be added to the PDL. Aspirin and warfarin will be preferred drugs and Pradaxa® will be a non-preferred drug. A quantity limit of 68 tablets per month applies to Pradaxa®.

BPH Agents, Alpha Reductase Inhibitors

Proscar® will no longer be a preferred drug excluded from the brand medically necessary policy. The Dispense As Written (DAW) code "6" will no longer be allowed on claims for Proscar®.

Finasteride will be a preferred drug. Effective for dates of service on and after January 1, 2011, finasteride will be moved to the Maximum Allowed Cost List; therefore, Proscar® will require brand medically necessary PA. Prior authorization requests for Proscar® must be submitted on the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083 (10/08).

Cytokine and Cell Adhesion Molecule Antagonist Drugs

ForwardHealth has revised clinical criteria for cytokine and cell adhesion molecule (CAM) antagonist drugs. Criteria for approval of a PA request for cytokine and CAM antagonist drugs for Core Plan members are the same as the clinical criteria requirements for the Standard Plan. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for Benchmark Plan or Basic Plan members.

Clinical Criteria for Ankylosing Spondylitis

Enbrel® and Humira® are preferred drugs used to treat ankylosing spondylitis.

Simponi™ is a non-preferred drug used to treat ankylosing spondylitis. For PA requests for Simponi™, the member must meet all clinical criteria below *and* experience a treatment failure on a preferred cytokine and CAM antagonist drug.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat ankylosing spondylitis are all of the following:

- The member has a diagnosis of ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation and the following is true.
- The member has moderate to severe axial symptoms of ankylosing spondylitis or the member has received **one** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Corticosteroids.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ A nonsteroidal anti-inflammatory drug (NSAID) or cyclo-oxygenase (COX-2) inhibitor drug.
  - ✓ Sulfasalazine.

Clinical Criteria for Crohn's Disease

Cimzia® and Humira® are preferred drugs used to treat Crohn's disease.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat Crohn's disease are all of the following:

- The member has a diagnosis of Crohn's disease.
- The member has moderate to severe symptoms of Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ 5-aminosalicylic (5-ASA).
  - ✓ 6-mercaptopurine (6MP).
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Methotrexate.
  - ✓ Sulfasalazine.

Clinical Criteria for Plaque Psoriasis

Enbrel® and Humira® are preferred drugs used to treat plaque psoriasis.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat plaque psoriasis are all of the following:

- The member has a diagnosis of plaque psoriasis and at least one of the following:
  - ✓ The member has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent or more of his or her body surface area.

- ✓ The member has a diagnosis of debilitating palmoplantar psoriasis.
- The prescription was written by a dermatologist through a dermatology consultation.
- The member has received **one** or more of the following treatments and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction:
  - ✓ Cyclosporine.
  - ✓ Methotrexate.
  - ✓ Phototherapy.
  - ✓ Soriatane.

Clinical Criteria for Psoriatic Arthritis

Enbrel® and Humira® are preferred drugs used to treat psoriatic arthritis.

Simponi™ is a non-preferred drug used to treat psoriatic arthritis. For PA requests for Simponi™, the member must meet all clinical criteria below *and* experience a treatment failure on a preferred cytokine and CAM antagonist drug.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat psoriatic arthritis are all of the following:

- The member has a diagnosis of psoriatic arthritis.
- The member has moderate to severe symptoms of psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The member has moderate to severe axial symptoms of psoriatic arthritis or the member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.

Clinical Criteria for Rheumatoid Arthritis and Polyarticular Juvenile Rheumatoid Arthritis

Cimzia®, Enbrel®, and Humira® are preferred drugs used to treat rheumatoid arthritis (RA). Enbrel® and Humira® are preferred drugs to treat polyarticular juvenile RA.

Kineret® and Simponi™ are non-preferred drugs used to treat RA. For PA requests for Kineret® and Simponi™, the member must meet all clinical criteria below *and* experience a treatment failure on a preferred cytokine and CAM antagonist drug. For PA requests for Simponi™, members must continue to take methotrexate in combination with Simponi™.

Clinical Criteria for Rheumatoid Arthritis

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat RA are all of the following:

- The member has a diagnosis of RA.
- The member has moderate to severe symptoms of rheumatoid arthritis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.
  - ✓ Penicillamine.
  - ✓ Sulfasalazine.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat polyarticular juvenile RA are all of the following:

- The member has a diagnosis of polyarticular juvenile RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.
  - ✓ Penicillamine.
  - ✓ Sulfasalazine.

Grandfathering for Kineret®

Kineret® is a non-preferred drug; however, Standard Plan, Core Plan, Medicaid, SeniorCare members who are currently taking Kineret® will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Kineret® will end for all members.

Kimeret® will be a noncovered drug for Core Plan members who are not grandfathered on the drug.

Kineret® continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Revised Forms

Prior authorization requests for cytokine and CAM antagonist drugs must be submitted on the appropriate revised PA/PDL for Cytokine and CAM Antagonist Drugs form. If cytokine and CAM antagonist drugs are being prescribed for more than one condition, providers should complete and submit the PA form most appropriate to the primary indication. Providers may refer to Attachments 3 through 12 for the following PA/PDL for Cytokine and CAM Antagonist Drugs completion instructions and forms:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304 (11/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305 (11/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306 (11/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307 (11/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA, F-11308 (11/10).

Prior authorization requests received by ForwardHealth on and after December 1, 2010, with PA/PDL for Cytokine and CAM Antagonist Drugs forms dated 10/08 will be returned to providers unprocessed.

Epinephrine, Self-Injected

As a reminder, Epi-pen® will not be covered for Core Plan members because generic epinephrine, auto-injector will be covered.

Multiple Sclerosis Agents

The multiple sclerosis agents drug class will be renamed the multiple sclerosis agents, immunomodulators drug class. In addition, the multiple sclerosis, oral agents drug class will be renamed multiple sclerosis agents, other.

Gilenya™ is new drug used to treat multiple sclerosis. Gilenya™ is a non-preferred drug in the multiple sclerosis

agents, immunomodulators drug class. Providers are required to submit PA requests for Gilyena™ on paper by fax or mail using the Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08), and the Prior Authorization Request Form (PA/RF), F-11018 (10/08). Clinical documentation supporting the use of Gilenya™ must be submitted with each PA request.

Clinical criteria for approval of a PA request for Gilenya™ are one of the following:

- The member has experienced a treatment failure with a preferred drug. If the member has experienced a treatment failure on the preferred product(s), indicate the drug on which the member experienced the treatment failure and the approximate dates the drug was taken.
- The member has a medical condition preventing the use of a preferred drug. If the member has a medical condition that prevents the use of a preferred drug, indicate the member's medical condition.
- The member has experienced a clinically significant drug interaction with a preferred drug. If the member has experienced a clinically significant drug interaction, indicate the medications and the drug interaction (s).
- The member has experienced a clinically significant drug reaction with a preferred drug. If the member has experienced a clinically significant drug reaction, indicate the medication and the drug reaction.

For PA requests for Gilenya™, providers are required to indicate clinical information about why the member cannot use a preferred drug and why it is medically necessary that the member receives Gilenya™ instead of a preferred drug.

Gilenya™ is a diagnosis-restricted drug. The allowable diagnosis code for Gilenya™ is 340 (Multiple sclerosis). An allowable diagnosis code must be indicated on claims and PA requests. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page in the Providers area of the Portal for the most current diagnosis codes.

Gilenya™ is not covered by the Benchmark Plan, the Core Plan, or the Basic Plan.

Ophthalmics, Glaucoma Agents

The ophthalmics, glaucoma agents will be split into multiple drug classes. The new drug class names will be the following:

- Ophthalmics, glaucoma — beta blockers.
- Ophthalmics, glaucoma — prostaglandins.
- Ophthalmics, glaucoma — other.

Preferred drugs in the ophthalmics, glaucoma — prostaglandins drug class will be covered for Core Plan members. Generic drugs in other ophthalmics, glaucoma drug classes may be covered for Benchmark Plan, Core Plan, and Basic Plan members. Providers may refer to the Benchmark Plan, Core Plan, and Basic Plan National Drug Code lists on the Pharmacy page in the Providers area of the Portal for more information about drugs covered by each benefit plan.

Members must meet PA criteria for drugs in the respective ophthalmics, glaucoma agents drug class before a PA request may be submitted for a non-preferred drug.

Lumigan® and Xalatan®

As a reminder, Xalatan® is a preferred drug and Lumigan® is a non-preferred drug that requires PA. Travatan-Z® continues to be a preferred drug.

For Core Plan members, Travatan Z® and Xalatan® will be covered and Lumigan® will no longer be covered.

Lumigan®, Travatan Z®, and Xalatan® will have a quantity limit of 5 mL per month. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page in the Providers area of the Portal for the most current quantity limits.

Trusopt® and Cosopt®

Trusopt® and Cosopt® will no longer be preferred drugs excluded from the brand medically necessary policy. The

DAW code "6" will no longer be allowed on claims for Trusopt® and Cosopt®.

Trusopt®, Cosopt®, dorzolamide, and dorzolamide with timolol will be preferred drugs. Effective for DOS on and after January 1, 2011, dorzolamide and dorzolamide with timolol will be moved to the Maximum Allowed Cost List; therefore, Trusopt® and Cosopt® will require brand medically necessary PA. Prior authorization requests for Trusopt® and Cosopt® must be submitted on the PA/BMNA.

Dorzolamide will be covered by the Benchmark Plan, the Core Plan, and the Basic Plan. Dorzolamide with timolol will not be covered by the Benchmark Plan, the Core Plan, or the Basic Plan.

Opioid Dependency Agents

Suboxone® film will be added as a preferred drug that requires clinical PA in the opioid dependency agents drug class. Prior authorization requests for Suboxone® film will be accepted on and after December 1, 2010. New and renewal PA requests for Suboxone® tablets will only be accepted on paper if the member's medical necessity has been documented.

Between December 1, 2010, and February 2, 2011, Standard Plan, Core Plan, Medicaid, and SeniorCare members with an approved PA for Suboxone® tablets may continue to receive Suboxone® tablets. Effective for DOS on and after February 1, 2011, PAs for Suboxone® tablets will no longer be valid. Prescribers should switch members prescriptions to Suboxone® film or provide clinical documentation about why the member cannot use Suboxone® film and why it is medically necessary the member receive Suboxone® tablets instead of the film.

Prior authorization requests for Suboxone® and buprenorphine will be approved for a maximum of 183 days per request and may be renewed for up to a maximum of two years. Prior authorization requests for Suboxone® and buprenorphine will not be approved for use outside treatment for opioid dependence. A diagnosis of opioid type dependence should be indicated on claims and PA requests for Suboxone® and buprenorphine.

Prior authorization requests for opioid dependency agents must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine, F-00081 (11/10). The PA/PDL for Suboxone and Buprenorphine has been revised. Providers may refer to Attachments 13 and 14 for the revised form and completion instructions.

Suboxone® tablets and buprenorphine continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

Prior Authorization Requests for Suboxone® Film

Prior authorization requests for Suboxone® film for Standard Plan, Medicaid, and SeniorCare members may be submitted using the STAT-PA system or on paper by fax or mail. For Core Plan members, PA requests for Suboxone® film may only be submitted on paper by fax or mail.

Prior Authorization Requests for Suboxone® Tablets

Prior authorization requests for Suboxone® tablets for Standard Plan, Medicaid, and SeniorCare members must be submitted on paper by fax or mail.

On and after February 2, 2011, Suboxone® tablets will be a noncovered drug for Core Plan members.

Clinical Criteria

Clinical criteria for approval of a PA request for Suboxone® and buprenorphine are all of the following:

- The member is 16 years of age or older.
- The drug is being prescribed by a physician who has obtained a Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone or buprenorphine for opioid dependence.

- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.

The prescribing physician must indicate that he or she has read the attestation statement on the form and that he or she agrees to follow guidelines set forth by the U.S. Department of Health and Human Services Federation of State Medical Boards — Model Policy Guidelines for Opioid Addiction Treatment.

Additional criteria for approval of a PA request for buprenorphine are as follows:

- The member is nursing or pregnant.
- The prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant and nursing women.
- The prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant and nursing women.

For PA requests for Suboxone® tablets, providers are required to indicate clinical information about why the member cannot use Suboxone® film and why it is medically necessary that the member received Suboxone® tablets instead of Suboxone® film.

Phosphate Binders

Phoslo® will no longer be a preferred drug excluded from the brand medically necessary policy. The DAW code "6" will no longer be allowed on claims for Phoslo®.

Calcium acetate will be a preferred drug. Effective for DOS on and after January 1, 2011, calcium acetate will be moved to the Maximum Allowed Cost List; therefore, Phoslo® will require brand medically necessary PA. Prior authorization requests for Phoslo® must be submitted on the PA/BMNA.

Skeletal Muscle Relaxants

Carisoprodol 350 mg will have a quantity limit of 136 tablets per month. Carisoprodol 350 mg will be covered for Standard Plan, Medicaid, and SeniorCare members.

As a reminder, Soma 250 mg has a quantity limit of 84 tablets per month. Soma 250 mg continues to be covered for Standard Plan, Medicaid, and SeniorCare members. For Benchmark Plan, Core Plan, and Basic Plan members, Soma 250 mg continues to be a noncovered drug.

Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page in the Providers area of the Portal for the most current quantity limits.

Stimulants and Related Agents

Clinical criteria for stimulants and related agents have changed and a section about Intuniv™ and Kapvay™ has been added to the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents form, F-11097 (11/10). Providers may refer to Attachments 15 and 16 for the revised form and completion instructions.

The following sections are on the PA/PDL for Stimulants and Related Agents form:

- Non-preferred drugs.
- Intuniv™ and Kapvay™ (when Kapvay™ is available in the marketplace).
- Strattera®.

For PA request for stimulants and related agents, providers should complete the section of the form appropriate to the drug being requested.

Clinical Criterion for Non-Preferred Stimulants

Clinical criterion for approval of a PA request for a non-preferred stimulant is the member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with two preferred stimulants.

Diagnosis restrictions continue for *all* stimulant and related agent drugs, except for Provigil® and Nuvigil®.

Clinical Criteria for Intuniv™ and Kapvay™

Intuniv™ and Kapvay™ will be non-preferred drugs in the stimulants and related agents drug class.

Clinical criteria for approval of a PA request for Intuniv™ and Kapvay™ require one of the following:

- The member will take Intuniv™ or Kapvay™ in combination with a preferred stimulant.
- The member has experienced a treatment failure with a preferred stimulant.
- The member has a medical condition preventing the use of a preferred stimulant.
- There is a clinically significant drug interaction between another medication the member is taking and a preferred stimulant.
- The member has experienced a clinically significant adverse drug reaction to a preferred stimulant.

Intuniv™ and Kapvay™ are diagnosis-restricted drugs. The allowable diagnosis codes for Intuniv™ and Kapvay™ are 314.00 (Attention deficit disorder of childhood without mention of hyperactivity) and 314.01 (Attention deficit disorder of childhood with hyperactivity). An allowable diagnosis code must be indicated on claims and PA requests. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page in the Providers area of the Portal for the most current diagnosis codes.

Intuniv™ and Kapvay™ are age-restricted drugs approved for members 6 through 20 years of age.

Clinical Criteria for Strattera®

Clinical criteria for approval of a PA request for Strattera® require one of the following:

- The member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with two preferred stimulants.
- The member has a medical condition (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 drug diversion.

Strattera® continues to be a covered drug for Standard Plan, Medicaid, SeniorCare, and transitioned Core Plan members. Transitioned Core Plan members are individuals enrolled in Milwaukee County's General Assistance Medical Program (GAMP) and other counties' general assistance medical programs who are now enrolled in the Core Plan.

Straterra® continues to be a noncovered drug for Benchmark Plan and Basic Plan members. For all Core Plan members except transitioned Core Plan members, Strattera® continues to be a noncovered drug.

Prior authorization for Straterra® cannot be obtained for Core Plan members.

Adderall XR®

Adderall XR® will no longer be a preferred drug and will instead require brand medically necessary PA. Prior authorization requests for Adderall XR® must be submitted on the PA/BMNA.

Amphetamine salt combination extended release continues to be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Amphetamine salt combination extended release continues to be covered by the Benchmark Plan, the Core Plan, and the Basic Plan.

Providers may refer to the Maximum Allowed Cost List on the Pharmacy page in the Providers area of the Portal for more information about drugs for which brand medically necessary PA is required.

Clinical Criteria for Xyrem®

Xyrem® continues to require clinical PA. Clinical criteria have been established for Xyrem®. Providers should submit

PA requests for Xyrem® by fax or mail using the PA/DGA, and a PA/RF.

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

- The member has a diagnosis of narcolepsy or narcolepsy with cataplexy.
- The member has experienced one of the following:
  - ✓ An unsatisfactory therapeutic response.
  - ✓ A clinically significant adverse drug reaction.
  - ✓ A medical condition that prevents treatment.
  - ✓ A clinically significant drug interaction between another medication that prevents treatment with all of the following:
    - Antidepressants.
    - Stimulants.
    - Provigil or Nuvigil.

For initial PA requests for Xyrem®, in addition to documenting on the PA/DGA the clinical information listed above, prescribers are required to submit documentation from the member's medical record that supports the member's diagnosis of narcolepsy or narcolepsy with cataplexy. In addition, test results from the member's polysomnogram (PSG) and multiple sleep latency test (MSLT) must be submitted.

An allowable diagnosis code must be indicated on claims and PA requests for Xyrem®. Allowable diagnosis codes for Xyrem® are 347.00 (Narcolepsy; without cataplexy) and 347.01 (Narcolepsy; with cataplexy). Prior authorization requests for Xyrem® will not be approved for use outside treatment for narcolepsy (e.g., for treatment for sleep disorders, hypersomnia, fatigue, or other medical conditions).

Initial PA requests for Xyrem® may be approved for a maximum of six months. Subsequent PA requests may be approved if the prescriber supplies documentation from the member's medical record of clinical improvement and patient compliance with medication use and safety precautions.

Xyrem® is a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members and SeniorCare members in levels 2b and 3.

Submitting Prior Authorization Requests

Prior authorization requests for non-preferred drugs in classes in this *Update* may be submitted via the following:

- The STAT-PA system.
- The ForwardHealth Portal.
- Paper by fax or mail.

Prior authorization requests submitted on paper for non-preferred drugs in classes in this *Update* must be submitted on the PA/PDL Exemption Request unless otherwise indicated.

For PA requests submitted using the STAT-PA system, providers are required to enter information into STAT-PA exactly as it is written on the form.

For all PA requests, prescribers are required to complete, physically sign, and date the appropriate PA form. Prescribers are required to submit the appropriate PA form along with any supporting documentation to the pharmacy where the prescription will be filled. Prescribers and pharmacy providers are required to keep a completed copy of the PA form.

For PA requests submitted using the Portal, the pharmacy provider is required to submit the PA request using the Portal and fax or mail the PA form and supporting documentation received from the prescriber to ForwardHealth.

For PA requests submitted by fax or mail, the pharmacy provider is required to complete, sign, date, and submit to ForwardHealth a PA/RF with the PA form and supporting documentation received from the prescriber.

For More Information

Providers may refer to the Pharmacy service area of the Online Handbook on the Portal for more information about PDL policies.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership are provided by the member's managed care organization. Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

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

P-1250

ATTACHMENT 1
Prior Authorization Drug Attachment for Anti-Obesity Drugs Completion Instructions

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00163A (11/10)

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 ANTI-OBESITY DRUGS COMPLETION INSTRUCTIONS

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

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Prior authorization requests for anti-obesity drugs submitted on paper require the use of this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Anti-Obesity Drugs form, F-00163, to request PA for anti-obesity drugs. Prescribers are required to retain a completed copy of the form.

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

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

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

3) For paper PA requests by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment to the following address:

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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER AND PROVIDER INFORMATION

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

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

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

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

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

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

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name
Check the box with the name of the appropriate drug.

Element 11 — Drug Strength
Enter the strength of the drug listed in Element 10.

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

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

Element 14 — Refills
Enter the number of refills.

SECTION III — CLINICAL INFORMATION

Element 15 — Diagnosis Code and Description
Enter the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 16 — Height — Member
Enter the member's height in inches.

Element 17 — Weight — Member
Enter the member's weight in pounds.

Element 18 — Date Member's Weight Was Measured
Enter the date the member's weight was measured in MM/DD/CCYY format.

Element 19 — Body Mass Index (BMI) — Member
Enter the member's current body mass index (BMI) using the following equation.

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

Example: Height = 5'9"
Weight = 230 lbs
Figure out height in inches: 5 x 12 = 60 + 9 = 69

$$\text{BMI} = \frac{703 \times 230}{69^2} \qquad \text{BMI} = \frac{161690}{4761} \qquad \text{BMI} = 33.96$$

Element 20 — Goal Weight — Member
Enter the member's goal weight in pounds. This should be a number agreed upon by the prescribing medical practitioner and the member.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS
Complete this section for initial and renewal requests for anti-obesity drugs.

Element 21
Indicate whether or not the member is pregnant or nursing.

Element 22
Indicate whether or not the member has a history of an eating disorder (e.g., anorexia, bulimia).

Element 23
Indicate the medication prescribed for the member. In addition, answer the questions below the drug name that apply to the member's medical history.

SECTION IV B — INITIAL COVERAGE REQUIREMENTS
Complete this section for initial requests for anti-obesity drugs.

Element 24
Indicate whether or not the member's BMI is greater than or equal to 30 or greater than or equal to 27 but less than 30 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, or type II diabetes mellitus. If applicable, indicate the member's current risk factors.

Element 25
Indicate whether or not the member has participated in a weight loss treatment plan in the past six months and if the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan.

SECTION V — AUTHORIZED SIGNATURE

Element 26 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 27 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 28
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

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

ATTACHMENT 2
Prior Authorization Drug Attachment for Anti-Obesity Drugs

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00163 (11/10)

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 ANTI-OBESITY DRUGS

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

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

SECTION I — MEMBER AND PROVIDER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

10. Drug Name (Check only one.)

❑ Xenical® (orlistat) ❑ benzphetamine ❑ diethylpropion ❑ phentermine ❑ phendimetrazine

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

SECTION III — CLINICAL INFORMATION

15. Diagnosis Code and Description

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

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

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

21. Is the member pregnant or nursing?	❑ Yes	❑ No
22. Does the member have a history of an eating disorder (e.g., anorexia, bulimia)?	❑ Yes	❑ No

Continued

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

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

A. ❑ Xenical® (orlistat).

❑ Does the member have chronic malabsorption syndrome?	❑ Yes	❑ No
❑ Does the member have cholestasis?	❑ Yes	❑ No

B. ❑ Benzphetamine, phendimetrazine, phentermine, or diethylpropion.

❑ Does the member have glaucoma?	❑ Yes	❑ No
❑ Does the member have hyperthyroidism?	❑ Yes	❑ No
❑ Does the member have advanced arteriosclerosis?	❑ Yes	❑ No
❑ Does the member have a history of drug abuse or misuse?	❑ Yes	❑ No
❑ Does the member have uncontrolled hypertension?	❑ Yes	❑ No
❑ Is the member hypersensitive to any sympathomimetic amines?	❑ Yes	❑ No

SECTION IV B — INITIAL COVERAGE REQUIREMENTS

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

A. ❑ The member's BMI is greater than or equal to 30.

B. ❑ The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors. Check the member's current risk factors.

- ❑ Coronary Heart Disease.
- ❑ Dyslipidemia.
- ❑ Hypertension.
- ❑ Sleep Apnea.
- ❑ Type II Diabetes Mellitus.

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

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

SECTION V — AUTHORIZED SIGNATURE

26. **SIGNATURE** — Prescriber	27. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

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

SECTION VII — FOR INTERNAL USE ONLY

- ❑ Initial request.
- ❑ Renewal request (Xenical®).
- ❑ Renewal request (benzphetamine, diethylpropion, phendimetrazine, or phentermine).

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS 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. 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 pharmacy providers 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis to request PA 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 to ForwardHealth at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 — 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.

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 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 ANKYLOSING SPONDYLITIS

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 description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 13
Check the appropriate box to indicate whether or not the member has a diagnosis of ankylosing spondylitis.

Element 14
Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

Element 15
Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of ankylosing spondylitis.

Element 16
Check the appropriate box to indicate whether or not the member has received **one** or more of the drugs listed on the PA/PDL form and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes is checked, check the box next to the drug(s) the member received and indicate the dose of the drug(s), specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s), and the approximate date(s) the drug(s) was taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Element 17
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred CAM antagonist drug. If yes is checked, indicate the preferred cytokine and CAM antagonist drug and dose and list specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred cytokine and CAM antagonist drug was taken 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 Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis 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 for each drug.

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

Element 22 — NPI
Enter the NPI of the pharmacy provider.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 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
Record the PA number assigned by the STAT-PA system.

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

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

Element 28 — Number of Days Approved
Record 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 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11304 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions, F-11304A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

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

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of ankylosing spondylitis?	❑ Yes	❑ No
14. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
15. Does the member have moderate to severe axial symptoms of ankylosing spondylitis?	❑ Yes	❑ No

Continued

DT-PA072-072

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS (Continued)

16. Has the member received **one** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the box next to the drug(s) the member received. Indicate the dose of the drug(s), specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s), and the approximate dates the drug(s) was taken in the space provided.

1. ❑ corticosteroids _____
2. ❑ leflunomide _____
3. ❑ methotrexate _____
4. ❑ NSAID or COX-2 _____
5. ❑ sulfasalazine _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

17. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, list the preferred cytokine and CAM antagonist drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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 5
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE 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. 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 pharmacy providers 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease to request PA 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 to ForwardHealth at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 — 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.

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 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 CROHN'S DISEASE

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 description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 13
Check the appropriate box to indicate whether or not the member has a diagnosis of Crohn's disease.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of Crohn's disease.

Element 15
Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

Element 16
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes is checked, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Element 17
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug. If yes is checked, indicate the preferred cytokine and CAM antagonist drug and dose and list specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred cytokine and CAM antagonist drug was taken 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 Cytokine and CAM Antagonist Drugs for Crohn's Disease 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 for each drug.

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

Element 22 — NPI
Enter the NPI of the pharmacy provider.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 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
Record the PA number assigned by the STAT-PA system.

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

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

Element 28 — Number of Days Approved
Record 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 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11305 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Instructions, F-11305A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

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

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE

12. Diagnosis Code and Description

13. Does the member have a diagnosis of Crohn's disease?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of Crohn's disease?	❑ Yes	❑ No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	❑ Yes	❑ No

Continued

DT-PA073-073

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE (Continued)

16. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

1. ❑ 5-aminosalicylic (5-ASA) _____
2. ❑ 6-mercaptopurine (6MP) _____
3. ❑ azathioprine _____
4. ❑ corticosteroids _____
5. ❑ methotrexate _____
6. ❑ sulfasalazine _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

17. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, list the preferred cytokine and CAM antagonist drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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 7
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS 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. 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 pharmacy providers 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis to request PA 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 to ForwardHealth at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 — 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.

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 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 PLAQUE PSORIASIS

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 description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 13
Check the appropriate box to indicate whether or not the member has a diagnosis of plaque psoriasis.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area.

Element 15
Check the appropriate box to indicate whether or not the member has a diagnosis of debilitating palmoplantar psoriasis.

Element 16
Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or through a dermatology consultation.

Element 17
Check the appropriate box to indicate whether or not the member has received **one** or more of the treatments listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction. If yes is checked, check the box next to the treatment(s) the member received and indicate the dose of the treatment(s), specific details about the unsatisfactory therapeutic response or clinically significant adverse reaction(s), and the approximate date(s) of the treatment(s) in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Element 18
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction to a preferred cytokine and cell adhesion molecule (CAM) antagonist drug. If yes is checked, indicate the preferred cytokine and CAM antagonist drug and dose and list specific details about the unsatisfactory therapeutic response or clinically significant adverse reaction and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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 PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis 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, up to 365 days.

Element 23 — NPI
Enter the NPI of the pharmacy provider.

Element 24 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 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
Record the PA number assigned by the STAT-PA system.

Element 27 — Grant Date
Record the date the PA request was approved by the STAT-PA system.

Element 28 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 29 — Number of Days Approved
Record the number of days for which the 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 8
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11306 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions, F-11306A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

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

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of plaque psoriasis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area?	❑ Yes	❑ No
15. Does the member have a diagnosis of palmoplantar psoriasis?	❑ Yes	❑ No
16. Is the prescription written by a dermatologist or through a dermatology consultation?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS (Continued)

17. Has the member received **one** or more of the treatments listed below and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction? ❑ Yes ❑ No

If yes, check the box next to the treatment(s) the member received. Indicate the dose of the treatment(s), specific details about the unsatisfactory therapeutic response or clinically significant adverse reaction(s), and the approximate date(s) of the treatment(s) in the space provided.

1. ❑ cyclosporine _____
2. ❑ methotrexate _____
3. ❑ phototherapy _____
4. ❑ Soriatane _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

18. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction to a preferred cytokine and molecule (CAM) antagonist drug? ❑ Yes ❑ No

If yes, list the preferred cytokine and CAM antagonist drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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 365 Days)

23. NPI

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 diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 9
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS 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. 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 pharmacy providers 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis to request PA 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 to ForwardHealth at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 — 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.

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 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 PSORIATIC ARTHRITIS

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 description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 13
Check the appropriate box to indicate whether or not the member has a diagnosis of psoriatic arthritis.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of psoriatic arthritis.

Element 15
Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.

Element 16
Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of psoriatic arthritis.

Element 17
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes is checked, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Element 18
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug. If yes is checked, indicate the preferred cytokine and CAM antagonist drug and dose and list specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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 PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis 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, up to 365 days.

Element 23 — NPI
Enter the NPI of the pharmacy provider.

Element 24 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 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
Record the PA number assigned by the STAT-PA system.

Element 27 — Grant Date
Record the date the PA request was approved by the STAT-PA system.

Element 28 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 29 — Number of Days Approved
Record the number of days for which the 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 10
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11307 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions, F-11307A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

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

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of psoriatic arthritis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of psoriatic arthritis?	❑ Yes	❑ No
15. Is the prescription written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation?	❑ Yes	❑ No
16. Does the member have moderate to severe axial symptoms of psoriatic arthritis?	❑ Yes	❑ No

Continued

DT-PA075-075

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS (Continued)

17. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space below.

1. ❑ azathioprine _____
2. ❑ corticosteroids _____
3. ❑ cyclosporine _____
4. ❑ hydroxychloroquine _____
5. ❑ leflunomide _____
6. ❑ methotrexate _____
7. ❑ NSAID or COX-2 _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

18. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, list the preferred cytokine and CAM antagonist drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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 365 Days)

23. NPI

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 diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 11
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis [RA] and Polyarticular Juvenile RA Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA) AND POLYARTICULAR JUVENILE RA 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. 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 pharmacy providers 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA, F-11308. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for RA and Polyarticular Juvenile RA to request PA 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 to ForwardHealth at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 — 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.

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 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 RA AND POLYARTICULAR JUVENILE RA

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 description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 13
Check the appropriate box to indicate whether or not the member has a diagnosis of polyarticular juvenile RA.

Element 14
Check the appropriate box to indicate whether or not the member has a diagnosis of RA.

Element 15
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of RA.

Element 16
Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

Element 17
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes is checked, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Element 18
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug. If yes is checked, indicate the preferred cytokine and CAM antagonist drug and dose and list specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS

Element 19
Check the appropriate box to indicate whether or not the member will continue to take methotrexate in combination with Simponi.

SECTION IV — AUTHORIZED SIGNATURE

Element 20 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 21 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for RA and Polyarticular Juvenile RA was signed (in MM/DD/CCYY format).

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

Element 22 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 23 — Days' Supply Requested
Enter the requested days' supply.

Element 24 — NPI
Enter the NPI of the pharmacy provider.

Element 25 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 26 — 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 27 — Assigned PA Number
Record the PA number assigned by the STAT-PA system.

Element 28 — Grant Date
Record the date the PA request was approved by the STAT-PA system.

Element 29 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 30 — Number of Days Approved
Record the number of days for which the PA request was approved by the STAT-PA system.

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 12
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis [RA] and Polyarticular Juvenile RA" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11308 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA) AND POLYARTICULAR JUVENILE RA

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA Completion Instructions, F-11308A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

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

SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE RA (Required for all requests.)

12. Diagnosis Code and Description

13. Does the member have a diagnosis of polyarticular juvenile rheumatoid arthritis?	❑ Yes	❑ No
14. Does the member have a diagnosis of rheumatoid arthritis?	❑ Yes	❑ No
15. Does the member have moderate to severe symptoms of rheumatoid arthritis?	❑ Yes	❑ No
16. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR RA AND POLYARTICULAR JUVENILE RA (Continued)

17. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space below.

1. ❑ azathioprine _____
2. ❑ corticosteroids _____
3. ❑ cyclosporine _____
4. ❑ hydroxychloroquine _____
5. ❑ leflunomide _____
6. ❑ methotrexate _____
7. ❑ NSAIDs or COX-2 _____
8. ❑ penicillamine _____
9. ❑ sulfasalazine _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

18. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, list the preferred cytokine and CAM antagonist drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS

19. Will the member continue to take methotrexate in combination with Simponi? ❑ Yes ❑ No

SECTION IV — AUTHORIZED SIGNATURE

20. **SIGNATURE** — Prescriber	21. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

22. National Drug Code (11 digits)	23. Days' Supply Requested (Up to 365 Days)

24. NPI

25. 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.)

Continued

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA (Continued)

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

27. Assigned PA Number

28. Grant Date	29. Expiration Date	30. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 13
Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR SUBOXONE AND BUPRENORPHINE 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.

INSTRUCTIONS

Attach the completed Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine, F-00081, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Note: For members enrolled in the BadgerCare Plus Core Plan, PA requests for Suboxone and buprenorphine must be submitted on paper by fax or mail. For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, PA requests for Suboxone and buprenorphine may be submitted using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or on paper by fax or mail.

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 — 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

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

This section must be completed for all requests.

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. The diagnosis code indicated must be an allowable diagnosis code for Suboxone or buprenorphine.

Element 14
Check the appropriate box to indicate whether or not the member is 16 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the prescribing physician is a Drug Addiction Treatment Act (DATA 2000)-waived physician. If yes, indicate the prescribing physician's "X" Drug Enforcement Administration (DEA) number in the space provided. Check no if the prescribing physician does not participate in this program.

Element 16
Check the appropriate box to indicate whether or not the member is taking any other opioids, tramadol, or carisoprodol. If yes is checked, list the drugs taken and the dates they were taken in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has any untreated or unstable psychiatric conditions that may interfere with compliance. If yes is checked, list the conditions in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member is pregnant or nursing.

SECTION IV — ATTESTATION

The physician is required to read and sign the attestation statement for consideration of the PA request.

Element 19
Check the appropriate box to indicate whether or not the prescribing physician has read the attestation statement.

Element 20
Check the appropriate box to indicate whether or not the prescribing physician agrees to follow the guidelines set forth by State Medical Boards for opioid addiction treatment.

Element 21 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 22 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE TABLET REQUESTS (Complete for pregnant or nursing women only.)

Element 23
Check the appropriate box to indicate whether or not the member is pregnant.

Element 24
Check the appropriate box to indicate whether or not the member is nursing.

Element 25
Check the appropriate box to indicate whether or not the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant or nursing women.

Element 26
Check the appropriate box to indicate whether or not the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women.

SECTION VI — ADDITIONAL CLINICAL INFORMATION FOR SUBOXONE TABLET REQUESTS

Element 27
Provide detailed clinical information why the member cannot use Suboxone film and why it is medically necessary that the member receive Suboxone tablets instead of Suboxone film in the space provided.

SECTION VII — AUTHORIZED SIGNATURE

Element 28 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 29 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VIII — FOR PHARMACY PROVIDERS USING STAT-PA

Element 30 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 31 — Days' Supply Requested
Enter the requested days' supply.

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

Element 32 — NPI
Enter the NPI.

Element 33 — 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 34 — Patient Location
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be dispensed.

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

Element 35 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 36 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 37 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 38 — Number of Days Approved
Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION IX — ADDITIONAL INFORMATION

Element 39
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 14
Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00081 (11/10)

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 / PREFERRED DRUG LIST (PA/PDL) FOR SUBOXONE AND BUPRENORPHINE

Instructions: Print or type clearly. Refer to the Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine Completion Instructions, F-00081A, for more information. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

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 (Check One) ❑ Suboxone film ❑ Buprenorphine tablet ❑ Suboxone tablet	5. Drug Strength (Check Strength[s]) ❑ 2 mg ❑ 8 mg
6. Date Prescription Written	7. Refills
8. Directions for Use	
9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber
11. Address — Prescriber (Street, City, State, ZIP+4 Code)	
12. Telephone Number — Prescriber	

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

13. Diagnosis Code and Description

14. Is the member 16 years of age or older? ❑ Yes ❑ No

15. Does the prescribing physician have a valid Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone and buprenorphine for opioid dependence? ❑ Yes ❑ No

    If yes, enter the prescribing physician's "X" Drug Enforcement Administration (DEA) number in the space provided.

16. Is the member taking any other opioids, tramadol, or carisoprodol? ❑ Yes ❑ No

    If yes, list the drugs taken and the dates they were taken in the space provided.

17. Does the member have any untreated or unstable psychiatric conditions that may interfere with compliance? ❑ Yes ❑ No

    If yes, list the conditions in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Required for all requests.) (Continued)

18. Is the member pregnant or nursing?	❑ Yes	❑ No

SECTION IV — ATTESTATION

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

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

19. Has the prescribing physician read the attestation statement?	❑ Yes	❑ No
20. Does the prescribing physician agree to follow the guidelines set forth by State Medical Boards for opioid addiction treatment?	❑ Yes	❑ No

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

SECTION V — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE TABLET REQUESTS (Complete for pregnant or nursing women only.)

23. Is the member pregnant?	❑ Yes	❑ No
24. Is the member nursing?	❑ Yes	❑ No
25. Has the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant or nursing women?	❑ Yes	❑ No
26. Has the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women?	❑ Yes	❑ No

SECTION VI — ADDITIONAL CLINICAL INFORMATION FOR SUBOXONE TABLET REQUESTS

27. Provide detailed clinical information why the member cannot use Suboxone film and why it is medically necessary that the member receive Suboxone tablets instead of Suboxone film.

SECTION VII — AUTHORIZED SIGNATURE

28. **SIGNATURE** — Prescriber	29. Date Signed

Continued

SECTION VIII — FOR PHARMACY PROVIDERS USING STAT-PA

30. National Drug Code (11 Digits)	31. Days' Supply Requested (Up to 183 Days)

32. NPI

33. 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.)

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

35. Assigned PA Number

36. Grant Date	37. Expiration Date	38. Number of Days Approved

SECTION IX — ADDITIONAL INFORMATION

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

ATTACHMENT 15
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.)

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

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 REQUESTS (Excluding Intuniv, Kapvay, and Strattera.)

Element 13
Check the appropriate box to indicate whether or not the member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants. If yes is checked, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA REQUESTS

Element 14
Check the appropriate box to indicate whether or not the member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants. If yes is checked, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

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 medical condition(s) in the space provided.

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

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

SECTION IIIC — CLINICAL INFORMATION FOR INTUNIV AND KAPVAY REQUESTS

Element 18
Check the appropriate box to indicate whether or not the member will take Intuniv or Kapvay in combination with a preferred stimulant. If yes is checked, list the preferred stimulant in the space provided.

Element 19
Check the appropriate box to indicate whether or not the member experienced a treatment failure with a preferred stimulant. If yes is checked, list the preferred stimulant, specific details about the treatment failure, and the approximate date(s) the preferred stimulant was taken in the space provided.

Element 20
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of a preferred stimulant. If yes is checked, list the medical condition(s) that prevents the use of a preferred stimulant in the space provided.

Element 21
Check the appropriate box to indicate whether or not there is a clinically significant adverse drug interaction between another medication the member is taking and a preferred stimulant. If yes is checked, list the medication(s) and interaction(s) in the space provided.

Element 22
Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction to a preferred stimulant. If yes is checked, list the name of the preferred stimulant, specific details about the clinically significant adverse drug reaction, and the approximate dates of the adverse drug reaction in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 23 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 24 — 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 25 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 26 — Days' Supply Requested
Enter the requested days' supply up to 365 days.

Element 27 — NPI
Enter the provider's NPI.

Element 28 — 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 29 — 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 30 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 31 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 32 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 33 — 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 34
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 16
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.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11097 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

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. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

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

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS (Required for all requests.)

12. Diagnosis Code and Description

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Intuniv, Kapvay, and Strattera.)

13. Has the member experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants? ❑ Yes ❑ No

If yes, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

List the drug names and doses, documentation regarding previous use, and approximate dates the preferred stimulants were taken below.

A.) _____

B.) _____

Continued

SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA REQUESTS

14. Has the member experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants? ❑ Yes ❑ No

If yes, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

List the drug names and doses, documentation regarding previous use, and approximate dates the preferred stimulants were taken below.

A.) _____

B.) _____

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 provided.

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

If yes, explain in the space provided.

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

If yes, explain in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR INTUNIV AND KAPVAY REQUESTS

18. Will the member take Intuniv or Kapvay in combination with a preferred stimulant? ❑ Yes ❑ No

If yes, list the preferred stimulant in the space provided.

19. Has the member experienced a treatment failure with a preferred stimulant? ❑ Yes ❑ No

If yes, list the preferred stimulant, specific details about the treatment failure, and the approximate date(s) the preferred stimulant was taken in the space provided.

20. Does the member have a medical condition(s) preventing the use of a preferred stimulant? ❑ Yes ❑ No

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

21. Is there a clinically significant drug interaction between another medication the member is taking and a preferred stimulant? ❑ Yes ❑ No

If yes, list the medication(s) and interaction(s) in the space provided.

Continued

SECTION IIIC — CLINICAL INFORMATION FOR INTUNIV AND KAPVAY REQUESTS (Continued)

22. Has the member experienced a clinically significant adverse drug reaction to a preferred stimulant? ❑ Yes ❑ No

If yes, list the name of the preferred stimulant, specific details about the clinically significant adverse drug reaction, and the approximate dates of the adverse drug reaction in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

25. National Drug Code (11 Digits)	26. Days' Supply Requested (Up to 365 Days)

27. NPI

28. 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.)

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

30. Assigned PA Number

31. Grant Date	32. Expiration Date	33. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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