ForwardHealth
Wisconsin serving you

Update
March 2010

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

Spring 2010 Preferred Drug List Review

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List and other pharmacy policy changes effective for dates of service on and after April 1, 2010.

The BadgerCare Plus Standard Plan, Medicaid, and SeniorCare have added one new drug class to the Preferred Drug List (PDL) and reviewed 31 existing drug classes. Changes in status may have occurred to preferred and non-preferred drugs in the reviewed classes. Changes to the PDL will be effective for dates of service (DOS) on and after April 1, 2010, unless otherwise noted.

This *ForwardHealth Update* provides an overview of the major changes to certain drug classes but does not address all of the changes made in drug classes. Providers may refer to the Wisconsin Medicaid, BadgerCare Plus, and SeniorCare Preferred Drug List — Quick Reference on the Pharmacy page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for the complete list of preferred and non-preferred drugs, including any changes in status for the PDL. Providers may refer to the BadgerCare Plus Core Plan National Drug Code List, the BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference, and the BadgerCare Plus Benchmark National Drug Code List on the Pharmacy page of the Portal for more information about drugs covered by the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan.

The PDL is not a drug formulary and is not a comprehensive list of drugs that are covered by the Standard Plan, Medicaid, and SeniorCare. Most drugs and drug classes are covered by the Standard Plan, Medicaid, and SeniorCare, but some drugs may have additional restrictions, including diagnosis, quantity limit, and age limit restrictions. Changes in this *Update* do not impact members enrolled in the Benchmark Plan or the Core Plan unless noted.

Submitting Prior Authorization Requests

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

- The Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system.
- The ForwardHealth Portal beginning May 1, 2010.
- Paper by fax or mail.

As a reminder, if a PA request is submitted on paper, prescribers are required to complete, sign, and date the appropriate PA form and submit it, along with any supporting documentation, to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete, sign, and submit a Prior Authorization Request Form (PA/RF), F-11018 (10/08), along with the PA form and supporting documentation submitted by the prescriber to ForwardHealth. Prior authorization requests submitted on paper for non-preferred drugs in classes in this *Update* must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/08), unless otherwise indicated.

New Drug Class for Fibromyalgia

The fibromyalgia drug class will be added to the PDL Quick Reference effective for DOS on and after April 1, 2010. Lyrica and Savella will be preferred drugs in the fibromyalgia drug class.

Analgesics, Narcotics (Short Acting and Long Acting)

The name of the analgesics, narcotics (short acting) and analgesics, narcotics (long acting) drug classes will change to the analgesics, opioids (short acting) and analgesics, opioids (long acting) drug classes.

Analgesics, Opioids (Short Acting)

As a result of safety concerns, propoxyphene and propoxyphene with acetaminophen products will be non-preferred drugs that require PA effective for DOS on and after July 1, 2010. Pharmacy providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the analgesics, opioids (short acting) drug class or request PA for a product containing propoxyphene.

ForwardHealth will accept PA requests for propoxyphene and propoxyphene with acetaminophen products beginning July 1, 2010.

For DOS on and after July 1, 2010, propoxyphene and propoxyphene with acetaminophen products will be noncovered drugs for members enrolled in the Benchmark Plan and the Core Plan.

Anticoagulants, Injectables

Innohep will be removed from the PDL Quick Reference and will be subject to current policies regarding covered and noncovered services.

Antimigraine Agents

Relpax will be a non-preferred drug that requires PA. Pharmacy providers should work with prescribers to either switch a member's prescription if medically appropriate to a preferred drug or request PA for Relpax. Sumatriptan and Maxalt are preferred drugs in the antimigraine agents drug class.

Angiotensin Modulators

With the anticipated release of a generic angiotensin II receptor blocker (ARB), changes will be made to the angiotensin modulators drug class. Avapro, Avalide, Benicar, and Benicar HCTZ will be non-preferred drugs in the angiotensin modulators drug class. Cozaar, Diovan, Diovan HCTZ, Hyzaar, and Micardis will be preferred ARBs in the angiotensin modulator drug class.

Angiotensin Modulators/CCB Combination

The name of the angiotensin modulators/CCB combination drug class will change to the angiotensin modulators combinations drug class.

Bladder Relaxants

Enablex and VesiCare will be preferred drugs in the bladder relaxant drug class.

Oxybutynin ER will remain a non-preferred drug; however, PA will not be required for oxybutynin ER for members who are 18 years of age or younger. For members 19 years of age or older, PA will be required for oxybutynin ER.

Detrol LA will be a non-preferred drug. Pharmacy providers should work with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the bladder relaxants drug class or request PA for Detrol LA.

Agents for BPH

The agents for BPH drug class will be split into two new drug classes. The drug classes will be titled BPH agents, adrenergic blockers and BPH agents, reductase inhibitors. Members must meet PA criteria for drugs in the respective BPH drug class before a PA request may be submitted for a non-preferred drug.

Lipotropics, Other

Effective for DOS on and after July 1, 2010, Zetia will be a non-preferred drug for members enrolled in the Standard Plan, Medicaid, and SeniorCare. Pharmacy providers should work with prescribers to either switch a member's prescription if medically appropriate to any preferred lipotropic drug listed on the PDL or request PA for Zetia. ForwardHealth will accept PA requests for Zetia beginning July 1, 2010.

Effective for DOS on and after July 1, 2010, the lipotropics, other drug class will no longer be a covered drug class for members enrolled in the Core Plan; therefore, Niacor, Niaspan, and Zetia will be noncovered drugs for members enrolled in the Core Plan. As a result, the lipotropics, other drug class has been removed from the BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference. Covered, generic lipotropics can be found on the BadgerCare Plus Core Plan National Drug Code List.

Multiple Sclerosis Agents

Avonex will be a non-preferred drug; however, members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare who are currently taking Avonex will be grandfathered. Providers will continue to be reimbursed for Avonex until the generic becomes available. After the generic becomes available, grandfathering of Avonex will end for all members.

Avonex will be a noncovered drug for members enrolled in the Core Plan if the members were not grandfathered on the drug. Members enrolled in the Core Plan do not have appeal rights for noncovered drugs or services.

Otics, Fluoroquinolones

The name of the otics, fluoroquinolones drug class will change to the otics, antibiotics drug class.

Proton Pump Inhibitors

ForwardHealth has revised and reinstated the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs, F-11078 (03/10). Effective for DOS on and after April 1, 2010, PA requests for non-preferred PPI drugs must be submitted on the PA/PDL for PPI Drugs form. Prior authorization requests effective for DOS on and after April 1, 2010, submitted on the PA/PDL for PPI Drugs form dated 03/09 or the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/08), will be returned to providers unprocessed. Providers may refer to Attachments 1 and 2 of this *Update* for the revised PA/PDL for PPI Drugs completion instructions and form.

Aciphex and federal legend omeprazole will be preferred drugs in the PPI drug class. For members enrolled in the Standard Plan, the Benchmark Plan, the Core Plan, and Medicaid, omeprazole OTC will be a noncovered drug. Omeprazole OTC remains a noncovered drug for SeniorCare members. For dual eligibles, omeprazole OTC will no longer be covered as a Medicare Part D excluded drug.

Lansoprazole will be a non-preferred drug for members enrolled in the Standard Plan, Medicaid, and SeniorCare. Lansoprazole will be a noncovered drug for members enrolled in the Benchmark Plan and the Core Plan.

Nexium 10 mg suspension, Nexium 20 mg suspension, and Prevacid SoluTab 15 mg remain non-preferred drugs; however, PA will *not* be required for Nexium 10 mg suspension, Nexium 20 mg suspension, and Prevacid SoluTab 15 mg for members 12 years of age or younger. Prior authorization requests for suspension products or orally disintegrating tablets for members 13 years of age or older must be submitted on the PA/PDL for PPI Drugs form.

A diagnosis code is required on all claims and PA requests for PPI drugs. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page of the Portal for a list of allowable diagnosis codes.

Criteria for approval of a PA request for non-preferred PPI drugs are the following:

- The member is unable to take Aciphex as a result of one of the following:
  - ✓ The member experienced a treatment failure on the maximum dose of Aciphex (20 mg/day).
  - ✓ The member experienced a clinically significant adverse drug reaction to Aciphex.
  - ✓ There is a clinically significant drug interaction between another medication the member is taking and Aciphex.
- The member is unable to take omeprazole as a result of one of the following:
  - ✓ The member experienced a treatment failure on the maximum dose of omeprazole (40 mg/day).
  - ✓ The member experienced a clinically significant adverse drug reaction to omeprazole.
  - ✓ There is a clinically significant drug interaction between another medication the member is taking and omeprazole.

Note: Members will be required to try and fail Aciphex *and* omeprazole before a PA request may be approved for a non-preferred PPI drug.

For PA requests for Protonix suspension or Prevacid SoluTab, a member must have a swallowing condition that prevents him or her from swallowing a tablet or capsule.

Criteria for approval of a PA request for Nexium suspension or Prilosec suspension are the following:

- The member is unable to take Protonix suspension as a result of one of the following:
  - ✓ The member experienced a treatment failure on the maximum dose of Protonix suspension (40 mg/day).
  - ✓ The member experienced a clinically significant adverse drug reaction to Protonix suspension.
  - ✓ There is a clinically significant drug interaction between another medication the member is taking and Protonix suspension.
- The member is unable to take Prevacid SoluTab as a result of one of the following:
  - ✓ The member experienced a treatment failure on the maximum dose of Prevacid SoluTab (30 mg/day).
  - ✓ The member experienced a clinically significant adverse drug reaction to Prevacid SoluTab.
  - ✓ There is a clinically significant drug interaction between another medication the member is taking and Prevacid SoluTab.

Note: Members will be required to try and fail Protonix suspension *and* Prevacid SoluTab before a PA request for Nexium suspension or Prilosec suspension may be approved.

Current, approved PAs will be honored until their expiration date.

Pulmonary Arterial Hypertension

Tracleer will be a preferred drug in the pulmonary arterial hypertension drug class for members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare.

Tyvaso and Ventavis will be added to the pulmonary arterial hypertension drug class as non-preferred drugs with diagnosis restrictions.

Sedative Hypnotics

As a result of safety concerns, effective for DOS on and after July 1, 2010, flurazepam will be a non-preferred drug that requires PA. Pharmacy providers should work with prescribers to either switch a member's prescription if medically appropriate to a preferred drug or request PA for flurazepam if it is medically necessary for a member to remain on flurazepam. ForwardHealth will accept PA requests for flurazepam beginning July 1, 2010.

Flurazepam will be a noncovered drug for members enrolled in the Benchmark Plan and the Core Plan effective for DOS on and after July 1, 2010.

Effective for DOS on and after April 1, 2010, temazepam 15 mg and temazepam 30 mg are preferred drugs. The

temazepam 7.5 mg and temazepam 22.5 mg are non-preferred drugs that require PA. Prior authorization requests must be submitted by fax or mail. Clinical documentation explaining why temazepam 15 mg or temazepam 30 mg is not appropriate for the member should be included with the PA request.

Note: All strengths of Restoril (i.e., 7.5 mg, 15 mg, 22.5 mg, 30 mg) require brand medically necessary PA. Members pay the brand-name copayment and providers are reimbursed the brand-name dispensing fee for all strengths of Restoril.

The following are preferred drugs in the sedative hypnotics drug class:

- Chloral hydrate.
- Estazolam.
- Rozerem.
- Temazepam 15 mg and 30 mg.
- Zaleplon.
- Zolpidem.

Obsolete Drug Class

The H. Pylori drug classes will be removed from the PDL Quick Reference effective for DOS on and after April 1, 2010, and drugs will no longer be preferred or non-preferred. A diagnosis code continues to be required on claims for drugs in the H. Pylori drug class. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page of the Portal for a list of allowable diagnosis codes.

Other Policy Changes Effective for Dates of Service On and After April 1, 2010

Bronchodilators, Beta Agonists

Albuterol 1.25 mg/3mL (0.042 percent) for inhalation will remain a non-preferred drug that requires PA; however, PA will no longer be required for members who are 12 years of age or younger. Albuterol 1.25 mg/3mL (0.042 percent) will be covered for members 12 years of age or younger who are enrolled in the Benchmark Plan.

Hypoglycemics, Adjunct Therapy

The hypoglycemics, adjunct therapy drug class will be split into two categories. ForwardHealth has created the hypoglycemics, glucagon-like peptide (GLP-1) agents drug class and the hypoglycemics, Symlin drug class.

Hypoglycemics, GLP-1 Agents

In the hypoglycemics, GLP-1 agents drug class, Byetta and Victoza will be non-preferred drugs that require clinical PA.

Prior authorization requests for GLP-1 agents must be submitted on the new Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents form, F-00238 (03/10). Prior authorization requests for GLP-1 agents may be submitted on the Portal, by fax to (608) 221-8616, or by mail to the following address:

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

Beginning May 1, 2010, PA requests received by ForwardHealth for GLP-1 agents must be on the Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents. Prior authorization requests for GLP-1 agents received on and after May 1, 2010, on the Prior Authorization Drug Attachment for Byetta and Symlin, F-00080 (06/09), will be returned to providers unprocessed.

Providers may refer to Attachments 3 and 4 for the Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents completion instructions and form.

The following are clinical criteria for approval of a PA request for Byetta:

- The member has Type II diabetes mellitus. (*Note:* Diagnosis code 250.00 or 250.02 should be indicated on PA requests for Byetta.)
- The member is 18 years of age or older.

- The member is not currently receiving basal- or meal-time insulin injections.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member is taking the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day) and the maximum effective dose of a sulfonylurea, and the member's HbA1c is still above 6.5 percent.
- One of the following applies to the member:
  - ✓ The member is taking the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day) and cannot tolerate sulfonylurea because of a drug interaction, adverse drug reaction, or because the sulfonylurea is contraindicated as a result of another medical condition, and the member's HbA1c is still above 6.5 percent.
  - ✓ The member is taking the maximum effective dose of a sulfonylurea and cannot tolerate metformin because of a drug interaction, adverse drug reaction, or because the metformin is contraindicated as a result of another medical condition, and the member's HbA1c is still above 6.5 percent.
  - ✓ The member cannot tolerate metformin or a sulfonylurea because of a drug interaction, adverse drug reaction, or because the drug is contraindicated as a result of another medical condition, and the member's HbA1c is still above 6.5 percent.

For PA requests for Victoza, members must meet the above clinical criteria for Byetta and try and fail on the maximum dose of Byetta.

Prior authorization requests for GLP-1 agents may be initially approved for six months. Renewal PA requests will be approved only if the member's hemoglobin (HbA1c) decreases by at least 0.5 percent from the member's initial HbA1c or if the member's initial HbA1c was above 7 percent and the HbA1c drops below 7 percent. Renewal PA requests will be approved for one year. For ongoing PA renewal requests, the member must continue to maintain the improved HbA1c value.

Current, approved PAs will be honored until their expiration date.

Hypoglycemics, Symlin

Symlin will be a non-preferred drug that requires clinical PA.

Prior authorization requests for Symlin must be submitted on the new Prior Authorization/Preferred Drug List (PA/PDL) for Symlin form, F-00080 (03/10). Prior authorization requests for Symlin may be submitted using the STAT-PA system, on the Portal, or by fax or mail.

Beginning May 1, 2010, PA requests received by ForwardHealth for Symlin must be on the PA/PDL for Symlin form. Prior authorization requests for Symlin received on and after May 1, 2010, on the Prior Authorization Drug Attachment for Byetta and Symlin will be returned to providers unprocessed.

Providers may refer to Attachments 5 and 6 for the Prior Authorization/Preferred Drug List (PA/PDL) for Symlin completion instructions and form.

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

- The member has Type I or Type II diabetes mellitus. (*Note:* Diagnosis code 250.00 to 250.03 should be indicated on PA requests for Symlin.)
- The member is not using the drug for weight loss.
- The member is currently receiving insulin injections.
- The member is currently receiving meal-time insulin injections.
- The member is 18 years of age or older.
- The member does not currently have or have a history of gastroparesis.
- The member does not currently have or have a history of hypoglycemia unawareness.

- The member has not obtained emergency treatment for severe hypoglycemia more than twice in the past six months.
- The member's HbA1c is less than nine percent.

Opioid Dependency Agents

The Prior Authorization Drug Attachment for Suboxone and Subutex, F-00081 (03/10), has been revised and renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine. For DOS on and after April 1, 2010, PA requests received by ForwardHealth for Suboxone and buprenorphine must be on the PA/PDL for Suboxone and Buprenorphine form.

Suboxone and buprenorphine will be added to the PDL Quick Reference as preferred drugs with clinical PA.

For members enrolled in the Standard Plan, Medicaid, and SeniorCare, PA requests for Suboxone and buprenorphine may be submitted using the STAT-PA system, the Portal, or by fax or mail. For members enrolled in the Core Plan, PA requests for Suboxone and buprenorphine must be submitted on the Portal or by fax or mail. Drugs in the opioid dependency agents drug class are not covered for members enrolled in the Benchmark Plan.

Providers may refer to Attachments 7 and 8 for the PA/PDL for Suboxone and Buprenorphine completion instructions and form.

The following are clinical criteria for approval of a PA request for Suboxone and buprenorphine:

- 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.
- 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.

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

- 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.

Prior authorization requests for Suboxone and buprenorphine will be approved for a maximum of 183 days per request 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 (diagnosis code 304.00-304.03) should be indicated on PA requests for Suboxone and buprenorphine.

Note: Subutex will be added to the Brand Medically Necessary Drugs That Require Prior Authorization data table on the Pharmacy page of the Portal.

For More Information

Providers may refer to the ForwardHealth Online Handbook on the Portal for more information about PDL policies. Providers may also refer to the PDL Quick Reference, the BadgerCare Plus Core Plan National Drug Code List, and the BadgerCare Plus Benchmark National Drug Code List for more information about covered drugs and services.

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/*.

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ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Proton Pump Inhibitor [PPI] Drugs Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) 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 services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the Pharmacy page of the ForwardHealth Online Handbook for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a determination about the request.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs form, F-11078. Pharmacy providers are required to use the PA/PDL for PPI Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

2) For requests submitted on the ForwardHealth Portal, providers may access *www.forwardhealth.wi.gov/.*

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

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

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

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

Note: Members will be required to try and fail Aciphex *and* omeprazole before a non-preferred PPI drug may be prescribed or members will be required to try and fail Protonix suspension *and* Prevacid SoluTab before Nexium suspension or Prilosec suspension may be prescribed.

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the name of the drug.

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

Element 6 — Date Prescription Written
Enter the date 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 FOR NON-PREFERRED PROTON PUMP INHIBITOR DRUGS

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for PPI Drugs form. Complete Section IIIA for PPI drugs, Section IIIB for PPI suspension and orally disintegrating tablets, or Section IIIC for Nexium suspension and Prilosec suspension.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis code for PPIs must be one of the PPI-approved codes.

SECTION IIIA — PROTON PUMP INHIBITORS

Element 14
Indicate whether or not the member has experienced a treatment failure on the maximum dose of Aciphex (20 mg/day). If yes, indicate the approximate dates Aciphex was taken in the space provided.

Element 15
Indicate whether or not the member has experienced a clinically significant adverse drug reaction to Aciphex. If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate date(s) Aciphex was taken in the space provided.

Element 16
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Aciphex. If yes, list the medication(s) and interaction(s) in the space provided.

Element 17
Indicate whether or not the member has experienced a treatment failure on the maximum dose of omeprazole (40 mg/day). If yes, indicate the approximate dates omeprazole was taken in the space provided.

Element 18
Indicate whether or not the member has experienced a clinically significant adverse drug reaction to omeprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate date(s) omeprazole was taken in the space provided.

Element 19
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and omeprazole. If yes, list the medication(s) and interaction(s) in the space provided.

SECTION IIIB — PROTON PUMP INHIBITOR SUSPENSIONS AND ORALLY DISINTEGRATING TABLETS

Element 20
Indicate whether or not the member has a swallowing condition that prevents him or her from swallowing a tablet or capsule. If yes, list the condition in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR NEXIUM SUSPENSION AND PRILOSEC SUSPENSION

Element 21
Indicate whether or not the member has experienced a treatment failure on the maximum dose of Protonix suspension (40 mg/day). If yes, indicate the approximate dates Protonix suspension was taken in the space provided.

Element 22
Indicate whether or not the member has experienced a clinically significant adverse drug reaction to Protonix suspension. If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Protonix suspension was taken in the space provided.

Element 23
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Protonix suspension. If yes, list the medication(s) and interaction(s) in the space provided.

Element 24
Indicate whether or not the member has experienced a treatment failure on the maximum dose of Prevacid SoluTab (30 mg/day). If yes, indicate the approximate dates Prevacid SoluTab was taken in the space provided.

Element 25
Indicate whether or not the member has experienced a clinically significant adverse drug reaction to Prevacid SoluTab. If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Prevacid SoluTab was taken in the space provided.

Element 26
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Prevacid SoluTab. If yes, list the medication(s) and interaction(s) in the space provided.

Element 27 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 28 — Date Signed
Enter the month, day, and year the PA/PDL for PPI Drugs form was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 29 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 30 — Days' Supply Requested
Enter the requested days' supply.

Element 31 — NPI
Enter the NPI.

Element 32 — 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 33 — 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 34 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 35 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 36 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 37 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 38
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Proton Pump Inhibitor [PPI] Drugs" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11078 (03/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) DRUGS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs Completion Instructions, F-11078A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/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 Proton Pump Inhibitor (PPI) Drugs signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. 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 FOR NON-PREFERRED PROTON PUMP INHIBITOR DRUGS

13. Diagnosis Code and Description

SECTION IIIA — PROTON PUMP INHIBITORS

14. Has the member experienced a treatment failure on the maximum dose of Aciphex (20 mg/day)? ❑ Yes ❑ No

If yes, indicate the approximate dates Aciphex was taken in the space provided.

15. Has the member experienced a clinically significant adverse drug reaction to Aciphex? ❑ Yes ❑ No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate date(s) Aciphex was taken in the space provided.

Continued

SECTION IIIA — PROTON PUMP INHIBITORS (Continued)

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

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

17. Has the member experienced a treatment failure on the maximum dose of omeprazole (40 mg/day)? ❑ Yes ❑ No

    If yes, indicate the approximate dates omeprazole was taken in the space provided.

18. Has the member experienced a clinically significant adverse drug reaction to omeprazole? ❑ Yes ❑ No

    If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate date(s) omeprazole was taken in the space provided.

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

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

SECTION IIIB — PROTON PUMP INHIBITOR SUSPENSIONS AND ORALLY DISINTEGRATING TABLETS

20. Does the member have a swallowing condition that prevents him or her from swallowing a tablet or capsule? ❑ Yes ❑ No

    If yes, list the condition in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR NEXIUM SUSPENSION AND PRILOSEC SUSPENSION

21. Has the member experienced a treatment failure on the maximum dose of Protonix suspension (40 mg/day)? ❑ Yes ❑ No

    If yes, indicate the approximate dates Protonix suspension was taken in the space provided.

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

    If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Protonix suspension was taken in the space provided.

Continued

SECTION IIIC — CLINICAL INFORMATION FOR NEXIUM SUSPENSION AND PRILOSEC SUSPENSION (Continued)

23. Is there a clinically significant drug interaction between another medication the member is taking and Protonix suspension? ❑ Yes ❑ No

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

24. Has the member experienced a treatment failure on the maximum dose of Prevacid SoluTab (30 mg/day)? ❑ Yes ❑ No

    If yes, indicate the approximate dates Prevacid SoluTab was taken in the space provided.

25. Has the member experienced a clinically significant adverse drug reaction to Prevacid SoluTab? ❑ Yes ❑ No

    If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Prevacid SoluTab was taken in the space provided.

26. Is there a clinically significant drug interaction between another medication the member is taking and Prevacid SoluTab? ❑ Yes ❑ No

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

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

29. National Drug Code (11 Digits)	30. Days' Supply Requested (Up to 365 Days)

31. NPI

32. 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.)

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

34. Assigned PA Number

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

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Glucagon-Like Peptide [GLP-1] Agents Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR GLUCAGON-LIKE PEPTIDE (GLP-1) 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 service.

Prior authorization requests for glucagon-like peptide (GLP-1) agents 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 Glucagon-Like Peptide (GLP-1) Agents form, F-00238, to request PA for GLP-1 drugs. Prescribers are required to retain a completed copy of the form.

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

1) For requests submitted on the ForwardHealth Portal, providers may access *www.forwardhealth.wi.gov/.*

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

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

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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the name of the drug.

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

Element 6 — Date Prescription Written
Enter the date 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 — Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

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

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

SECTION III — CLINICAL INFORMATION

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The diagnosis code must correspond with the ICD-9-CM description. The diagnosis code indicated must be an allowable diagnosis code for GLP-1 agents.

Element 14
Indicate whether or not the member is 18 years of age or older.

Element 15
Indicate whether or not the member is currently receiving basal or meal-time insulin injections.

Element 16
Indicate whether or not the member currently has or has a history of pancreatitis.

Element 17
Indicate whether or not the member currently has or has a history of gastroparesis.

Element 18
Indicate the goal hemoglobin (HbA1c) for the member.

Element 19
Indicate whether or not the member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.

SECTION IIIA — CURRENT MEDICATION REGIMEN

Element 20
Indicate the member’s most current HbA1c.

Element 21
Indicate the date the member’s most current HbA1c was measured.

Element 22
List all the hypoglycemic medications the member was taking at the time of the HbA1c measurement in the columns.

Element 23
Indicate whether or not the member is currently taking the same medications listed in Element 22, including the same doses of medications and the same directions for use. If the member is not currently taking the same medications listed in Element 22, list the current hypoglycemic medications the member is taking, including the doses of medications and directions for use, in the columns.

SECTION IIIB — CLINICAL INFORMATION FOR METFORMIN

Element 24
Indicate whether or not the member is currently taking metformin. If yes, indicate the drug name, dose, and directions for use in the space provided.

Element 25
Indicate whether or not the member has been titrated to the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day). If no, indicate the reason(s) (e.g., medical condition, drug interaction, adverse drug reaction) why the member is not taking the maximum effective dose of metformin in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR A SULFONYLUREA

Element 26
Indicate whether or not the member is currently taking a sulfonylurea. If yes, indicate the drug name, dose, and directions for use in the space provided.

Element 27
Indicate whether or not the member has been titrated to the maximum dose of the sulfonylurea indicated in Element 26. If no, indicate the reason(s) (e.g., medical condition, drug interaction, adverse drug reaction) why the member is not taking the maximum effective dose of a sulfonylurea in the space provided.

SECTION IIID — CLINICAL INFORMATION FOR VICTOZA

Element 28
Indicate whether or not the member has tried and failed on the maximum dose of Byetta. If yes, indicate the dose, directions for use, and the approximate dates Byetta was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 29 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 30 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — 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 4
Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents

(A copy of the "Prior Authorization Drug Attachment for Glucagon-Like Peptide [GLP-1] Agents" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00238 (03/10)

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 GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions, F-00238A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents signed by the prescriber before submitting a PA request.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Is the member 18 years of age or older?	❑ Yes	❑ No
15. Is the member currently receiving basal or meal-time insulin injections?	❑ Yes	❑ No
16. Does the member currently have or have a history of pancreatitis?	❑ Yes	❑ No
17. Does the member currently have or have a history of gastroparesis?	❑ Yes	❑ No
18. What is the goal HbA1c for the member? _____		
19. Is the member participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control?	❑ Yes	❑ No

Continued

SECTION IIIA — CURRENT MEDICATION REGIMEN

20. State the member's most current HbA1c.	21. Date Member's HbA1c Measured
_____%	

22. List all the hypoglycemic medications the member was taking at the time of the HbA1c measurement in the columns below.

Medication Name	Medication Dose	Directions for Use
a.	a.	a.
b.	b.	b.
c.	c.	c.
d.	d.	d.
e.	e.	e.

23. Is the member currently taking the same medications listed in Element 22, including the same doses of medications and the same directions for use? ❑ Yes ❑ No

If no, list the current hypoglycemic medications the member is taking, including the doses of medications and directions for use in the columns below.

Medication Name	Medication Dose	Directions for Use
a.	a.	a.
b.	b.	b.
c.	c.	c.
d.	d.	d.
e.	e.	e.

SECTION IIIB — CLINICAL INFORMATION FOR METFORMIN

24. Is the member currently taking metformin? ❑ Yes ❑ No

If yes, indicate the drug name, dose, and directions for use in the space provided.

25. Is the member titrated to the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day)? ❑ Yes ❑ No

If no, indicate the reason(s) (e.g., medical condition, drug interaction, adverse drug reaction) why the member is not taking the maximum effective dose of metformin in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR A SULFONYLUREA

26. Is the member currently taking a sulfonylurea? ❑ Yes ❑ No

If yes, indicate the drug name, dose, and directions for use in the space provided.

27. Is the member titrated to the maximum effective dose of the sulfonylurea indicated in Element 26? ❑ Yes ❑ No

If no, indicate the reason(s) (e.g., medical condition, drug interaction, adverse drug reaction) why the member is not taking the maximum effective dose of a sulfonylurea in the space provided.

Continued

SECTION IIID — CLINICAL INFORMATION FOR VICTOZA

28. Has the member tried and failed on the maximum dose of Byetta? ❑ Yes ❑ No

If yes, list the dose, directions for use, and the approximate dates Byetta was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

29. **SIGNATURE** — Prescriber	30. Date Signed

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL) for Symlin Completion Instructions

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

FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR SYMLIN COMPLETION INSTRUCTIONS

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

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

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

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Symlin form, F-00080. Pharmacy providers are required to use the PA/PDL for Symlin form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

2) For requests submitted on the ForwardHealth Portal, providers may access *www.forwardhealth.wi.gov/.*

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

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

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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the name of the drug.

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

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

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 Symlin.

Element 14
Enter the member's most current hemoglobin (HbA1c) test results.

Element 15 — Date Member's HbA1c Measured
Enter the date of the HbA1c test from Element 14 in MM/DD/CCYY format. The date must be within a year of the requested start date.

Element 16
Indicate whether or not the member is using Symlin for weight loss.

Element 17
Indicate whether or not the member is currently receiving insulin injections.

Element 18
Indicate whether or not the member is currently receiving meal-time insulin injections.

Element 19
Indicate whether or not the member is 18 years of age or older.

Element 20
Indicate whether or not the member currently has or has a history of gastroparesis.

Element 21
Indicate whether or not the member currently has or has a history of hypoglycemia unawareness.

Element 22
Indicate whether or not the member has required emergency treatment for severe hypoglycemia in the past six months and, if yes, check the appropriate box to indicate how many times.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 23 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 24 — Days' Supply Requested
Enter the requested days' supply.

Element 25 — NPI
Enter the NPI.

Element 26 — Date of Service
Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 27 — Patient Location
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be dispensed.

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

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

Element 29 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 30 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 31 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — AUTHORIZED SIGNATURE

Element 32 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 33 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 34
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 6
Prior Authorization/Preferred Drug List (PA/PDL) for Symlin

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00080 (03/10)

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 SYMLIN

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Symlin Completion Instructions, F-00080A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/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 Symlin 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. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. State the member's most current HbA1c. _____ %	15. Date Member's HbA1c Measured

16. Is the member using Symlin for weight loss?	❑ Yes	❑ No
17. Is the member currently receiving insulin injections?	❑ Yes	❑ No
18. Is the member currently receiving meal-time insulin injections?	❑ Yes	❑ No
19. Is the member 18 years of age or older?	❑ Yes	❑ No
20. Does the member currently have or have a history of gastroparesis?	❑ Yes	❑ No
21. Does the member currently have or have a history of hypoglycemia unawareness?	❑ Yes	❑ No
22. Has the member required emergency treatment for severe hypoglycemia in the past six months?	❑ Yes	❑ No

If yes, how many times?
- ❑ Zero
- ❑ One
- ❑ Two
- ❑ Three or greater

Continued

SECTION VI — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 365 Days)

25. NPI

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

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

28. Assigned PA Number

29. Grant Date	30. Expiration Date	31. Number of Days Approved

SECTION V — AUTHORIZED SIGNATURE

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 7
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.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00081A (03/10)

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 COMPLETION INSTRUCTIONS

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

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

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

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone and Buprenorphine form, 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 the ForwardHealth Portal at *www.forwardhealth.wi.gov/* or 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, the Portal, or 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 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

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

SECTION II — PRESCRIPTION INFORMATION

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
Indicate whether or not the member is 16 years of age or older.

Element 15
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" DEA number in the space provided. Check no if the prescribing physician does not participate in this program.

Element 16
Indicate whether or not the member is taking other opioids, tramadol, or carisoprodol. If yes, list the drugs taken and the dates they were taken in the space provided.

Element 17
Indicate whether or not the member has any untreated or unstable psychiatric conditions that may interfere with compliance. If yes, list the conditions in the space provided.

Element 18
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
Indicate whether or not the prescribing physician has read the attestation statement.

Element 20
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 — CLINICAL INFORMATION FOR BUPRENORPHINE

Element 23
Indicate whether or not the member is pregnant.

Element 24
Indicate whether or not the member is nursing.

Element 25
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
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.

Element 27 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 28 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — FOR PHARMACY PROVIDERS USING STAT-PA

Element 29 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 30 — Days' Supply Requested
Enter the requested days' supply.

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

Element 31 — NPI
Enter the NPI.

Element 32 — 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 33 — 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 34 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 35 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 36 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 37 — Number of Days Approved
Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VII — ADDITIONAL INFORMATION

Element 38
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 8
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 (03/10)

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/Tab/42/icscontent/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. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name (Check One) ❑ Suboxone ❑ Buprenorphine

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" 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.

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

Continued

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 — CLINICAL INFORMATION FOR BUPRENORPHINE (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

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

SECTION VI — FOR PHARMACY PROVIDERS USING STAT-PA

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

31. NPI

32. 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 VI — FOR PHARMACY PROVIDERS USING STAT-PA (Continued)

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

34. Assigned PA Number

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

SECTION VII — ADDITIONAL INFORMATION

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