ForwardHealth
Wisconsin serving you

Update
June 2010

No. 2010-57

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

July 2010 Preferred Drug List Review and Other Pharmacy Policy Changes

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

This *ForwardHealth Update* provides an overview of the changes to Preferred Drug List (PDL) drug classes. Providers may refer to the following resources on the Pharmacy page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for the complete list of preferred and non-preferred drugs for drugs covered by the benefit plan:

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

The following resources, also available on the Pharmacy page of the Portal, provide complete lists of drugs covered by benefit plan:

- The BadgerCare Plus Benchmark Plan Covered National Drug Code List.
- The BadgerCare Plus Core Plan National Drug Code List.
- The BadgerCare Plus Basic Plan National Drug Code List.

Changes to the PDL are effective for dates of service (DOS) on and after July 1, 2010, unless otherwise noted.

This *Update* also provides information about prior authorization (PA) policy changes.

Analgesics, Opioids (Long Acting) and Opioid Dependency Agents

The "ER" (overuse) prospective Drug Utilization Review (DUR) policy will be applied to most drugs in the analgesics, opioids (long acting) drug class and all drugs in the opioid dependency agents drug class. Claims will be denied if a member requests a refill of a drug before 80 percent of the previous claim's days supply has been taken. Providers will receive Explanation of Benefits (EOB) code 7019, which states "Early Refill Alert. Policy override must be granted by the Drug Authorization and Policy Override Center to dispense early," on claims for these drugs. To request authorization to refill a drug early when EOB 7019 is received, providers may call the Drug Authorization and Policy Override (DAPO) Center at (800) 947-9627, option 7.

Providers may refer to the Early Refill Drug Utilization Review Drugs data table on the Pharmacy page of the Portal for the current list of drugs for which the "ER" DUR policy applies. Providers should refer to the list often, as the list may change.

Analgesics, Opioids (Short Acting)

Fentanyl Mucosal Agents

Prior authorization requests for the following non-preferred fentanyl mucosal agents must be submitted on the new Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents form, F-00281 (06/10):

- Fentanyl citrate oral transmucosal lozenges.
- Fentora.
- Onsolis.

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

Fentanyl Citrate Oral Transmucosal Lozenges

Clinical criteria for approval of a PA request for fentanyl citrate oral transmucosal lozenges are the following:

- The member has cancer that is causing persistent pain.
- The member is tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain.
- The member is currently taking a long-acting opioid analgesic drug.
- The member has breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs.

Fentora and Onsolis

For PA requests for Fentora and Onsolis, members must meet the previously listed clinical criteria for approval of a PA request for fentanyl citrate oral transmucosal lozenges. In addition, one of the following clinical criteria must be met:

- The member has previously taken fentanyl citrate oral transmucosal lozenges for cancer pain and experienced an unsatisfactory therapeutic response.
- The member has a medical condition that prevents him or her from taking fentanyl citrate oral transmucosal lozenges.

Prior authorization requests for fentanyl mucosal agents may be approved for a maximum of 183 days.

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

Prior Authorization Requests for Other Non-preferred Analgesics, Opioids (Short Acting)

Prior authorization requests for all other non-preferred drugs in the analgesics, opioids (short acting) drug class must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/08). Providers may refer to the PDL Quick Reference to determine which PA form must be submitted.

Quantity Limits

Effective for DOS on and after July 1, 2010, quantity limits will apply to meperidine.

Effective for DOS on and after September 1, 2010, quantity limits will apply to the following preferred and non-preferred drugs:

- Butalbital products.
- Codeine products.
- Levorphanol.
- Opioid analgesics with acetaminophen.
- Opioid analgesics with aspirin.
- Opioid analgesics with ibuprofen.
- Propoxyphene products.
- Tramadol products.

Providers should refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Portal for a list of drugs for which a monthly quantity limit applies and their associated quantity limits.

Providers may dispense up to the allowed quantity to members, but may not exceed the quantity limit without requesting a quantity limit override. To request an override of a quantity limit, providers may call the

DAPO Center. Providers may refer to the ForwardHealth Online Handbook for more information about quantity limits.

Propoxyphene Reminder

As a reminder, effective for DOS on and after July 1, 2010, propoxyphene and propoxyphene with acetaminophen products will be non-preferred drugs for members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare. Propoxyphene and propoxyphene with acetaminophen products will be noncovered drugs for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan.

Antimigraine Agents, Triptans

The name of the antimigraine agents, triptans drug class will change to the migraine agents, triptans drug class. In addition, butalbital products will be moved from the migraine agents, triptans drug class to a new drug class titled analgesics, miscellaneous.

New Step Therapy Policy

A step therapy policy will be implemented for triptans. Sumatriptan and Maxalt are preferred drugs. Members must try and fail any dosage form of sumatriptan before taking Maxalt. Members must try and fail any dosage form of sumatriptan and any dosage form of Maxalt before PA may be requested for a non-preferred triptan.

Claims

A claim for any dosage form of sumatriptan or any dosage form of Maxalt must be in the member's claims history in the last 365 days before a claim for any dosage form of Maxalt may be approved. If a claim for any dosage form of sumatriptan or any dosage form of Maxalt is not present in the member's claims history in the last 365 days, PA is required for Maxalt.

Prior Authorization Requests

Prior authorization requests for triptans must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Migraine Agents, Triptans form, F-00280 (06/10). Providers may refer to Attachments 3 and 4 for the PA/PDL for Step Therapy for Migraine Agents, Triptans completion instructions and form.

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

Clinical Criteria for Maxalt

The clinical criteria for Maxalt and Maxalt MLT is that the member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response.

Clinical Criteria for Non-preferred Migraine Agents, Triptans

Clinical criteria for approval of a PA request for non-preferred migraine agents, triptans are that the member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response and the member has previously taken Maxalt or Maxalt MLT within the last 365 days and experienced an unsatisfactory therapeutic response.

Analgesics, Miscellaneous

Butalbital products will be moved from the antimigraine agents drug class to a new drug class titled analgesics, miscellaneous. Butalbital products will be non-preferred drugs. Members will be required to try and fail over-the-counter (OTC) analgesic drugs before butalbital products may be prescribed. In addition to butalbital products, the following preferred OTC drugs will be in the analgesics, miscellaneous drug class:

- Acetaminophen.
- Aspirin.
- Ibuprofen OTC.
- Naproxen OTC.

Note: Ibuprofen OTC will be moved from the NSAIDs drug class to the analgesics, miscellaneous drug class.

Providers may refer to the PDL Quick Reference and benefit plan-specific National Drug Code lists on the Pharmacy page of the Portal for lists of covered OTC drugs.

Cymbalta

Cymbalta is listed in both the fibromyalgia drug class and the antidepressants, other drug class on the PDL.

Quantity Limits

Quantities for prescriptions for Cymbalta 20 mg, 30 mg, and 60 mg are limited to a total of 68 capsules per member, per month, regardless of the strength.

Providers may dispense up to the allowed quantity to members, but may not exceed the quantity limit without requesting a quantity limit override. To request an override of a quantity limit, providers may call the DAPO Center. Providers may refer to the Online Handbook for more information about quantity limits.

Prior Authorization Requests

A step therapy policy will be implemented for Cymbalta. Cymbalta is a non-preferred drug that requires PA.

Prior authorization requests for Cymbalta must be submitted on the most appropriate new PA/PDL for Step Therapy for Cymbalta form. If Cymbalta is being prescribed for more than one indication, providers should complete and submit the PA form most appropriate to the primary indication. Providers may refer to Attachments 5 through 12 for the following PA/PDL for Step Therapy for Cymbalta completion instructions and forms:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN), F-00285 (06/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Fibromyalgia, F-00282 (06/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD), F-00283 (06/10).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD), F-00284 (06/10).

Cymbalta is not covered by the Benchmark Plan, the Core Plan, or the Basic Plan; however, for Core Plan members who were grandfathered on Cymbalta, effective for DOS on and after July 1, 2009, Cymbalta continues to be covered.

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

Clinical Criteria for Cymbalta for Diabetic Peripheral Neuropathy

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

- The member has a diagnosis of DPN.
- The member has Type I or Type II diabetes.
- The member has previously taken Lyrica for DPN and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to Lyrica, or
- There is a clinically significant drug interaction between another medication the member is taking and Lyrica, or
- The member has a medical condition or contraindication that prevents him or her from taking Lyrica.

Members must try and fail Lyrica before PA may be requested for Cymbalta.

Clinical Criteria for Cymbalta for Fibromyalgia

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

- The member has previously taken Lyrica for fibromyalgia and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to Lyrica, or
- There is a clinically significant drug interaction between another medication the member is taking and Lyrica, or
- The member has a medical condition or contraindication that prevents him or her from taking Lyrica, and
- The member has taken Savella for fibromyalgia and experienced an unsatisfactory therapeutic response.
- The member experienced a clinically significant adverse drug reaction to Savella, or
- There is a clinically significant drug interaction between another medication the member is taking and Savella, or
- The member has a medical condition or contraindication that prevents him or her from taking Savella.

Members must try and fail Lyrica and Savella before PA may be requested for Cymbalta.

Clinical Criteria for Cymbalta for Generalized Anxiety Disorder

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

- The member has a diagnosis of GAD.
- The member has previously taken any formulation of paroxetine for GAD and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to paroxetine, or
- There is a clinically significant drug interaction between another medication the member is taking and paroxetine, or
- The member has a medical condition or contraindication that prevents him or her from taking paroxetine, and
- The member has taken any formulation of venlafaxine for GAD and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to venlafaxine.

Members must try and fail paroxetine and venlafaxine before PA may be requested for Cymbalta.

Clinical Criteria for Cymbalta for Major Depressive Disorder

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

- The member has a diagnosis of MDD.
- The member has previously taken a preferred selective serotonin reuptake inhibitor (SSRI) drug for MDD and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to an SSRI drug, or
- The member has taken other preferred antidepressant drugs for MDD and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to other preferred antidepressant drug(s), or
- The member is currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response, and
- The member has not taken drug-company provided samples of Cymbalta in the past 30 days.

Members must try and fail a preferred SSRI drug and other preferred antidepressant drugs before PA may be requested for Cymbalta.

Lipotropics Drug Classes

ForwardHealth has reorganized the lipotropics drug

classes on the PDL into the following classes:

- Lipotropics, bile acid sequestrants.
- Lipotropics, fibric acids.
- Lipotropics, Lovaza.
- Lipotropics, niacin.
- Lipotropics, other.
- Lipotropics, statins.

Preferred Drug List status changes have not been made to drugs listed in the lipotropics, bile acid sequestrants; lipotropics, fibric acids; or lipotropics, Lovaza drug classes.

Providers should ensure they are submitting PA requests for non-preferred lipotropics on the appropriate PA request form.

Lipotropics, Niacin

Niacor and Niaspan will be preferred drugs in the lipotropics, niacin drug class.

Lipotropics, Other

Vytorin and Zetia will be added to the PDL in the lipotropics, other drug class. Vytorin will be a preferred drug.

A step therapy policy will be implemented for Zetia. Zetia will be a non-preferred drug that requires PA. Members must try and fail a preferred 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitor (i.e., statin) drug and Vytorin before PA may be requested for Zetia. Prior authorization requests for Zetia for members enrolled in the Standard Plan, Medicaid, and SeniorCare must be submitted on the new Prior Authorization/Preferred Drug List (PA/PDL) for Zetia form, F-00279 (06/10). Providers may refer to Attachments 13 and 14 for the PA/PDL for Zetia completion instructions and form.

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

- The member is being treated for an elevated total cholesterol level, or
- The member is being treated for an elevated low-density lipoprotein cholesterol level, and
- The member has taken a preferred statin drug for at least three consecutive months and experienced an unsatisfactory therapeutic response, and
- The member has taken Vytorin for at least three consecutive months and experienced an unsatisfactory therapeutic response, or
- The member has a medical condition or contraindication that prevents him or her from taking a statin drug, or
- There is a clinically significant drug interaction between another medication the member is taking and a statin drug, or
- The member has experienced a clinically significant adverse drug reaction to a statin drug.

As a reminder, 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 a noncovered drug 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.

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

Multiple Sclerosis, Oral Agents

ForwardHealth has separated the multiple sclerosis agents drug class into two classes, the multiple sclerosis agents and multiple sclerosis, oral agents. Ampyra is a non-preferred drug that requires clinical PA in the multiple sclerosis, oral agents drug class. Providers should submit PA requests for Ampyra on paper 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 Ampyra must be submitted with the PA request.

A diagnosis code must be indicated on claims and PA requests for Ampyra.

Clinical Criteria for Ampyra

Clinical information that must be documented on PA requests for Ampyra are the following:

- The type of multiple sclerosis (MS) with which the member has been diagnosed.
- When the member was diagnosed with MS.
- The date of the member's last relapse and how complete the member's recovery was.
- The member's ambulation ability, including the distance, length of time, and the assistive devices he or she uses.
- When the member's ambulation ability was last measured.
- The measurement used to document ambulation ability, including the measurement that will be used to continue to document ambulation improvement or decline.

Providers are required to measure the member's ambulation before PA is requested for Ampyra, prior to the renewal of a PA request for Ampyra at six months of treatment, and at least yearly when the member is taking Ampyra.

Initial PA requests for Ampyra may be approved for 183 days. If ambulation improves, renewal PA requests for Ampyra may be approved for one year.

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

Sedative Hypnotics

As a reminder, effective for DOS on and after July 1, 2010, flurazepam will be a non-preferred drug for members enrolled in the Standard Plan, Medicaid, and SeniorCare. Flurazepam will be a noncovered drug for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan.

Cayston

A new drug for cystic fibrosis, Cayston, requires PA. Providers should submit PA requests for Cayston on paper using the PA/DGA and the PA/RF. Clinical documentation supporting the use of Cayston must be submitted with each PA request.

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

- The member has a diagnosis of cystic fibrosis.
- The prescriber has confirmed the member currently has a positive sputum culture for Pseudomonas aeruginosa or the member had a positive sputum culture for Pseudomonas aeruginosa within the past 12 months. Providers should indicate the date of the positive sputum culture.
- The prescriber has confirmed the member currently does not have Burkholderia cepacia colonized in the lungs.
- The member is 7 years of age or older.
- The member has previously used Tobramycin Inhalation Solution (TOBI) and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response. Providers should indicate the specific details about the clinically significant adverse drug reaction or the unsatisfactory therapeutic response and the approximate dates TOBI was taken on the PA request.
- The prescriber has confirmed the member's forced expiratory volume in 1 second (FEV1) percent predicted is greater than or equal to 25 percent and less than or equal to 75 percent. Providers should indicate the member's current FEV1 percent predicted on the PA request.
- The member is not receiving treatment with other inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents, including alternating treatment schedules. Providers should provide a history of all

inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents and a history of all systemic antibiotics/anti-infective agents within the most recent 90-day period.

The following are PA request approval criteria for Cayston:

- Prior authorization requests may be approved for a maximum of a 28 days supply per dispensing.
- Prior authorization requests may be approved with an alternating month treatment schedule of one month of Cayston treatment with one month of no inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents.
- Prior authorization requests may be approved for a maximum approval period of 183 days.

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

Submitting Prior Authorization Requests

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

Prior authorization requests may be submitted via the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system, by fax, or by 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 PA/RF along with the PA form and supporting documentation submitted by the prescriber to ForwardHealth.

Prior Authorization Requests Submitted on the Portal

Effective on July 1, 2010, the PA/DGA and the PA/RF may be completed and submitted on the Portal.

Prior Authorization Drug Attachment forms and PA/PDL forms may only be submitted via the STAT-PA system or by fax or mail. Prior authorization requests with the Prior Authorization Drug Attachment forms or PA/PDL forms can be submitted using the Portal, but the attachments must be faxed or mailed separately.

For More Information

Providers may refer to the Pharmacy service area of the Online Handbook on the Portal for more information about PDL policies. Providers may refer to the PDL Quick Reference on the Pharmacy page of the Portal for the complete list of preferred and non-preferred drugs, including any changes in status, on the PDL.

Information Regarding Managed Care Organizations

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

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

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

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

P-1250

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR FENTANYL MUCOSAL 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. 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 Fentanyl Mucosal Agents form, F-00281. Pharmacy providers are required to use the PA/PDL for Fentanyl Mucosal Agents 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 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 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 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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Fentanyl Mucosal Agents form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member has cancer that is causing persistent pain.

Element 15
Indicate whether or not the member is tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain.

Element 16
Indicate whether or not the member is currently taking a long-acting opioid analgesic drug(s). If yes, list the long-acting analgesic drug(s) and the dose(s) the member is currently taking in the space provided.

Element 17
Indicate whether or not the member has experienced breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs. If yes, list the short-acting analgesic drug(s) and dose(s) the member has previously taken in the space provided.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF FENTANYL CITRATE ORAL TRANSMUCOSAL LOZENGES

Element 18
Indicate whether or not the member has previously taken fentanyl citrate oral transmucosal lozenges.

Element 19
Indicate whether or not the member has taken fentanyl lozenges for breakthrough cancer pain and experienced an unsatisfactory therapeutic response. If yes, indicate the approximate dates fentanyl lozenges were taken in the space provided.

Element 20
Indicate whether or not the member has a medical condition(s) that prevents him or her from taking fentanyl lozenges. If yes, list the medical condition(s) in the space provided.

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 PA/PDL for Fentanyl Mucosal Agents form was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

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

Element 25 — 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 — ADDITIONAL INFORMATION

Element 32
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 Fentanyl Mucosal Agents (For Photocopying)

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00281 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR FENTANYL MUCOSAL AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions, F-00281A. 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 Fentanyl Mucosal Agents 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

13. Diagnosis Code and Description

14. Does the member have cancer that is causing persistent pain?	❑ Yes	❑ No
15. Is the member tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain?	❑ Yes	❑ No
16. Is the member currently taking a long-acting opioid analgesic drug(s)?	❑ Yes	❑ No

If yes, list the long-acting opioid analgesic drug(s) and dose(s) the member is currently taking in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

17. Does the member experience breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs? ❑ Yes ❑ No

    If yes, list the short-acting opioid analgesic drug(s) and dose(s) the member has previously taken in the space provided.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF FENTANYL CITRATE ORAL TRANSMUCOSAL LOZENGES

18. Has the member previously taken fentanyl citrate oral transmucosal lozenges? ❑ Yes ❑ No

19. Has the member taken fentanyl lozenges for breakthrough cancer pain and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

    If yes, indicate the approximate dates fentanyl lozenges were taken in the space provided.

20. Does the member have a medical condition(s) that prevents him or her from taking fentanyl lozenges? ❑ Yes ❑ No

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

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 183 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 — ADDITIONAL INFORMATION

32. 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/Preferred Drug List (PA/PDL) for Step Therapy for Migraine Agents, Triptans Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Migraine Agents, Triptans Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR MIGRAINE AGENTS, TRIPTANS 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 Step Therapy for Migraine Agents, Triptans form, F-00280. Pharmacy providers are required to use the PA/PDL for Step Therapy for Migraine Agents, Triptans 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 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 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: A step therapy policy applies to migraine agents, triptans. Members must try and fail any dosage form of sumatriptan before taking Maxalt. Members must try and fail any dosage form of sumatriptan *and* any dosage form of Maxalt before PA may be requested for a non-preferred triptan.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Migraine Agents, Triptans form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF SUMATRIPTAN

Element 14
Indicate whether or not the member has previously taken any dosage form of sumatriptan.

Element 15
If the member has previously taken sumatriptan, check the dosage form(s) of sumatriptan.

Element 16
Indicate whether or not the member has taken sumatriptan and experienced an unsatisfactory therapeutic response.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF MAXALT OR MAXALT MLT

Element 17
Indicate whether or not the member has previously taken Maxalt or Maxalt MLT.

Element 18
Indicate whether or not the member has taken Maxalt or Maxalt MLT within the last 365 days and experienced an unsatisfactory therapeutic response. If yes, indicate the month and year (in MM/CCYY format) the member experienced the unsatisfactory therapeutic response to Maxalt or Maxalt MLT in the space provided.

SECTION IIIC — ADDITIONAL INFORMATION FOR NON-PREFERRED TRIPTAN PRIOR AUTHORIZATION REQUESTS

Element 19
A step therapy requirement for triptans began July 1, 2010. Indicate whether or not a PA request has been approved for the member for the non-preferred triptan listed in Element 4 since July 1, 2010. If no, indicate additional clinical information supporting the request for the non-preferred triptan in Element 31.

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 Step Therapy for Migraine Agents, Triptans form was signed (in MM/DD/CCYY format).

SECTION IV — 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.

Element 25 — 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 26 — 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 27 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

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

Element 29 — Expiration Date
Indicate 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 STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 31
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 4
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Migraine Agents, Triptans (For Photocopying)

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Migraine Agents, Triptans" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00280 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR MIGRAINE AGENTS, TRIPTANS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Migraine Agents, Triptans Completion Instructions, F-00280A. 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 Step Therapy for Migraine Agents, Triptans 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

13. Diagnosis Code and Description

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF SUMATRIPTAN

14. Has the member previously taken any dosage form of sumatriptan? ❑ Yes ❑ No

15. If the member has previously taken any dosage form of sumatriptan, check the dosage form(s) of sumatriptan the member has tried below.

1. ❑ sumatriptan oral
2. ❑ sumatriptan nasal
3. ❑ sumatriptan injection

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF SUMATRIPTAN (Continued)

16. Has the member taken sumatriptan and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF MAXALT OR MAXALT MLT

17. Has the member previously taken Maxalt or Maxalt MLT? ❑ Yes ❑ No

18. Has the member taken Maxalt or Maxalt MLT within the last 365 days and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

If yes, indicate the month and year the member experienced the unsatisfactory therapeutic response to Maxalt or Maxalt MLT below.

___ ___ (Month) ___ ___ ___ ___ (Year)

SECTION IIIC — ADDITIONAL INFORMATION FOR NON-PREFERRED TRIPTAN PRIOR AUTHORIZATION REQUESTS

19. A step therapy requirement for triptans began July 1, 2010. Since July 1, 2010, has a PA request been approved for the member for the non-preferred triptan listed in Element 4? ❑ Yes ❑ No

If no, indicate additional clinical information supporting the request for the non-preferred triptan in Element 31.

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

SECTION IV — 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.)

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 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 also be included here.

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN) Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy [DPN] Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR DIABETIC PERIPHERAL NEUROPATHY (DPN) 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 Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN) form, F-00285. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for DPN 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 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 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: A step therapy policy applies for Cymbalta. Members must try and fail Lyrica before PA may be requested for Cymbalta.

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
This element is populated with Cymbalta.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Cymbalta for DPN form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member has a diagnosis of DPN.

Element 15
Indicate whether or not the member has Type I diabetes.

Element 16
Indicate whether or not the member has Type II diabetes.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA

Element 17
Indicate whether or not the member has previously taken Lyrica.

Element 18
Indicate whether or not the member has taken Lyrica for DPN and experienced an unsatisfactory therapeutic response. If yes, indicate the approximate dates Lyrica was taken in the space provided.

Element 19
Indicate whether or not the member has experienced a clinically significant adverse drug reaction to Lyrica. If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate date(s) Lyrica was taken in the space provided.

Element 20
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Lyrica. If yes, list the medication(s) and interaction(s) in the space provided.

Element 21
Indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking Lyrica. If yes, list the medical condition(s) or contraindication(s) in the space provided.

Element 22 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 23 — Date Signed
Enter the month, day, and year the PA/PDL for Step Therapy for Cymbalta for DPN form was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

Element 25 — Days' Supply Requested
Enter the requested days' supply.

Element 26 — NPI
Enter the NPI.

Element 27 — 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 28 — 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 29 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 30 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 31 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 32 — 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 33
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 Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN) (For Photocopying)

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy [DPN]" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00285 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR DIABETIC PERIPHERAL NEUROPATHY (DPN)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN) Completion Instructions, F-00285A. 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 Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN) 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 Cymbalta	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

13. Diagnosis Code and Description

14. Does the member have a diagnosis of DPN?	❑ Yes	❑ No
15. Does the member have Type I diabetes?	❑ Yes	❑ No
16. Does the member have Type II diabetes?	❑ Yes	❑ No

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA

17. Has the member previously taken Lyrica?	❑ Yes	❑ No
18. Has the member taken Lyrica for DPN and experienced an unsatisfactory therapeutic response?	❑ Yes	❑ No

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

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA (Continued)

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

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

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

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

21. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking Lyrica? ❑ Yes ❑ No

    If yes, list the medical condition(s) or contraindication(s) in the space provided.

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

26. NPI

27. 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.)

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

29. Assigned PA Number

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

SECTION V — ADDITIONAL INFORMATION

33. 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 Step Therapy for Cymbalta for Fibromyalgia Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Fibromyalgia Completion Instructions" is located on

(This page was intentionally left blank.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR FIBROMYALGIA 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 Step Therapy for Cymbalta for Fibromyalgia form, F-00282. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for Fibromyalgia 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 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 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: A step therapy policy applies for Cymbalta. Members must try and fail Lyrica and Savella before PA may be requested for Cymbalta.

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
This element is populated with Cymbalta.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Cymbalta for Fibromyalgia form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member has a diagnosis of fibromyalgia.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA

Element 15
Indicate whether or not the member has previously taken Lyrica.

Element 16
Indicate whether or not the member has taken Lyrica for fibromyalgia and experienced an unsatisfactory therapeutic response. If yes, indicate the approximate dates Lyrica was taken in the space provided.

Element 17
Indicate whether or not the member has experienced a clinically significant adverse drug reaction to Lyrica. If yes, list the specific details about the clinically significant adverse drug reaction(s) and the approximate dates Lyrica was taken in the space provided.

Element 18
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Lyrica. If yes, list the medication(s) and interaction(s) in the space provided.

Element 19
Indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking Lyrica. If yes, list the medical condition(s) or contraindication(s) in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF SAVELLA

Element 20
Indicate whether or not the member has previously taken Savella.

Element 21
Indicate whether or not the member has taken Savella for fibromyalgia and experienced an unsatisfactory therapeutic response. If yes, indicate the approximate dates Savella was taken in the space provided.

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

Element 24
Indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking Savella. If yes, list the medical condition(s) or contraindication(s) in the space provided.

Element 25 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 26 — Date Signed
Enter the month, day, and year the PA/PDL for Step Therapy for Cymbalta for Fibromyalgia form was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 27 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 28 — Days' Supply Requested
Enter the requested days' supply.

Element 29 — NPI
Enter the NPI.

Element 30 — 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 31 — 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 32 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 33 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 34 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 35 — 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 36
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 8
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Fibromyalgia (For Photocopying)

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00282 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR FIBROMYALGIA

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Fibromyalgia Completion Instructions, F-00282A. 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 Step Therapy for Cymbalta for Fibromyalgia 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 Cymbalta	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

13. Diagnosis Code and Description

14. Does the member have a diagnosis of fibromyalgia? ❑ Yes ❑ No

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA

15. Has the member previously taken Lyrica? ❑ Yes ❑ No

16. Has the member taken Lyrica for fibromyalgia and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

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

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF LYRICA (Continued)

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

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

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

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

19. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking Lyrica? ❑ Yes ❑ No

    If yes, list the medical condition(s) or contraindication(s) in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF SAVELLA

20. Has the member previously taken Savella? ❑ Yes ❑ No

21. Has the member taken Savella for fibromyalgia and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

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

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

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

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

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

24. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking Savella? ❑ Yes ❑ No

    If yes, list the medical condition(s) or contraindication(s) in the space provided.

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

27. National Drug Code (11 Digits)	28. Days' Supply Requested (Up to 365 Days)

29. NPI

30. 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 IV — FOR PHARMACY PROVIDERS USING STAT-PA (Continued)

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

32. Assigned PA Number

33. Grant Date	34. Expiration Date	35. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

36. 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 9
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Generalized Anxiety Disorder [GAD] Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR GENERALIZED ANXIETY DISORDER (GAD) 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 Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) form, F-00283. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for GAD 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 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 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: A step therapy policy applies for Cymbalta. Members must try and fail paroxetine and venlafaxine before PA may be requested for Cymbalta.

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
This element is populated with Cymbalta.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Cymbalta for GAD form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member has a diagnosis of GAD.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PAROXETINE

Element 15
Indicate whether or not the member has previously taken paroxetine.

Element 16
Indicate whether or not the member has taken any formulation of paroxetine for GAD and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates paroxetine was taken in the space provided.

Element 17
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and paroxetine. If yes, list the medication(s) and interaction(s) in the space provided.

Element 18
Indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking paroxetine. If yes, list the medical condition(s) or contraindication(s) in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF VENLAFAXINE

Element 19
Indicate whether or not the member has taken any formulation of venlafaxine for GAD and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates venlafaxine was taken in the space provided.

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 Step Therapy for Cymbalta for GAD form was signed (in MM/DD/CCYY format).

SECTION IV — 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.

Element 25 — 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 26 — 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 27 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

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

Element 29 — Expiration Date
Indicate 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 STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 31
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 10
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) (For Photocopying)

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Generalized Anxiety Disorder [GAD]" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00283 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR GENERALIZED ANXIETY DISORDER (GAD)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) Completion Instructions, F-00283A. 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 Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) 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 Cymbalta	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

13. Diagnosis Code and Description

14. Does the member have a diagnosis of GAD? ❑ Yes ❑ No

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PAROXETINE

15. Has the member previously taken paroxetine? ❑ Yes ❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PAROXETINE (Continued)

16. Has the member taken any formulation of paroxetine for GAD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates paroxetine was taken in the space provided.

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

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

18. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking paroxetine? ❑ Yes ❑ No

    If yes, list the medical condition(s) or contraindication(s) in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF VENLAFAXINE

19. Has the member taken any formulation of venlafaxine for GAD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates venlafaxine was taken in the space provided.

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

SECTION IV — 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.)

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 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 also be included here.

ATTACHMENT 11
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Major Depressive Disorder [MDD] Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR MAJOR DEPRESSIVE DISORDER (MDD) 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 Step Therapy for Cymbalta for Major Depressive Disorder (MDD) form, F-00284. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for MDD 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 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 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: A step therapy policy applies for Cymbalta. Members must try and fail a preferred selective serotonin reuptake inhibitor (SSRI) drug and another preferred antidepressant drug before PA may be requested for Cymbalta.

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
This element is populated with Cymbalta.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Cymbalta for MDD form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member has a diagnosis of MDD.

Element 15
Indicate whether or not the member is currently taking Cymbalta for MDD.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED SELECTIVE SEROTONIN REUPTAKE INHIBITOR DRUGS

Element 16
Indicate whether or not the member has previously taken a preferred SSRI drug for MDD and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, check the name(s) of the preferred SSRI drug(s) the member has taken and indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred SSRI drug(s) was taken on the lines adjacent to the drug name.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF OTHER PREFERRED ANTIDEPRESSANT DRUGS

Element 17
Indicate whether or not the member has previously taken other preferred antidepressant drugs for MDD and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes, check the name(s) of the other preferred antidepressant drug(s) the member has taken and indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred antidepressant drug(s) was taken on the lines adjacent to the drug name.

SECTION IIIC — CLINICAL INFORMATION FOR CURRENT USE OF CYMBALTA

Element 18
Indicate whether or not the member is currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response.

Element 19
Indicate whether or not the member has taken drug-company provided samples of Cymbalta in the past 30 days.

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 Step Therapy for Cymbalta for MDD form was signed (in MM/DD/CCYY format).

SECTION IV — 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.

Element 25 — 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 26 — 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 27 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

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

Element 29 — Expiration Date
Indicate 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 STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 31
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 12
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) (For Photocopying)

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Step Therapy for Cymbalta for Major Depressive Disorder [MDD]" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00284 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR MAJOR DEPRESSIVE DISORDER (MDD)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) Completion Instructions, F-00284A. 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 Step Therapy for Cymbalta for Major Depressive Disorder (MDD) 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 Cymbalta	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

13. Diagnosis Code and Description

14. Does the member have a diagnosis of MDD?	❑ Yes	❑ No
15. Is the member currently taking Cymbalta for MDD?	❑ Yes	❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED SELECTIVE SEROTONIN REUPTAKE INHIBITOR DRUGS

16. Has the member previously taken a preferred selective serotonin reuptake inhibitor (SSRI) drug for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the name(s) of the preferred SSRI drug(s) the member has taken.

1. ❑ citalopram _____
2. ❑ fluoxetine _____
3. ❑ fluvoxamine _____
4. ❑ paroxetine _____
5. ❑ sertraline _____

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred SSRI drug(s) was taken on the line(s) adjacent to the drug name(s) above.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF OTHER PREFERRED ANTIDEPRESSANT DRUGS

17. Has the member previously taken a preferred antidepressant drug for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the name(s) of the other preferred antidepressant drug(s) the member has taken.

1. ❑ bupropion _____
2. ❑ bupropion XL _____
3. ❑ bupropion SR _____
4. ❑ Effexor XR _____
5. ❑ venlafaxine _____

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the other preferred antidepressant drug(s) was taken on the line(s) adjacent to the drug name(s) above.

SECTION IIIC — CLINICAL INFORMATION FOR CURRENT USE OF CYMBALTA

18. Is the member currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response? ❑ Yes ❑ No

19. Has the member taken drug-company provided samples of Cymbalta in the past 30 days? ❑ Yes ❑ No

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

SECTION IV — 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.)

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

Continued

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

27. Assigned PA Number

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

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 also be included here.

ATTACHMENT 13
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Zetia Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR ZETIA 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 Step Therapy for Zetia form, F-00279. Pharmacy providers are required to use the PA/PDL for Step Therapy for Zetia 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 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 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: A step therapy policy applies for Zetia. Members must try and fail a preferred 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitor (i.e., statin) drug and Vytorin before PA may be requested for Zetia.

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
This element is populated with Zetia.

Element 5 — Drug Strength
This element is populated with a drug strength of 10 mg.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Zetia form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member is being treated for an elevated total cholesterol level.

Element 15
Indicate whether or not the member is being treated for an elevated low-density lipoprotein cholesterol level.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF 3-HYDROXY-3-METHYLGLUTARYL COENZYME A (HMG-COA) REDUCTASE INHIBITOR (I.E., STATIN) DRUGS

Element 16
Indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking a 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitor (i.e., statin) drug. If yes, list the medical condition(s) or contraindication(s) in the space provided.

Element 17
Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and a statin drug. If yes, list the medication(s) and interaction(s) in the space provided.

Element 18
Indicate whether or not the member is currently taking or has previously taken a statin drug.

Element 19
Indicate whether or not the member experienced a clinically significant adverse drug reaction to a statin drug. If yes, list the name of the drug, specific details about the clinically significant adverse drug reaction, and the approximate dates of the adverse drug reaction in the space provided.

Element 20
Indicate whether or not the member has taken a preferred statin drug for at least three consecutive months and experienced an unsatisfactory therapeutic response. If yes, list the name of the drug, the dose of the drug, and the approximate dates the drug was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF VYTORIN

Element 21
Indicate whether or not the member is currently taking or has previously taken Vytorin.

Element 22
Indicate whether or not the member has taken Vytorin for at least three consecutive months and experienced an unsatisfactory therapeutic response. If yes, list the dose of Vytorin and the approximate dates Vytorin was taken in the space provided.

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 Step Therapy for Zetia form was signed (in MM/DD/CCYY format).

SECTION IV — 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.

Element 27 — NPI
Enter the NPI.

Element 28 — 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 29 — 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 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
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — 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 14
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Zetia (For Photocopying)

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00279 (06/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR ZETIA

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Zetia Completion Instructions, F-00279A. 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 Step Therapy for Zetia 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 Zetia	5. Drug Strength 10 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

13. Diagnosis Code and Description

14. Is the member being treated for an elevated total cholesterol level?	❑ Yes	❑ No
15. Is the member being treated for an elevated low-density lipoprotein cholesterol level?	❑ Yes	❑ No

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF 3-HYDROXY-3-METHYLGLUTARYL COENZYME A (HMG-COA) REDUCTASE INHIBITOR (I.E. STATIN) DRUGS

16. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking a 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitor (i.e., statin) drug? ❑ Yes ❑ No

If yes, list the medical condition(s) or contraindication(s) in the space provided.

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF 3-HYDROXY-3-METHYLGLUTARYL COENZYME A (HMG-COA) REDUCTASE INHIBITOR (I.E. STATIN) DRUGS (Continued)

17. Is there a clinically significant drug interaction with another medication the member is taking and a statin drug? ❑ Yes ❑ No

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

18. Is the member currently taking or has the member previously taken a statin drug? ❑ Yes ❑ No

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

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

20. Has the member taken a preferred statin drug for at least three consecutive months and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

    If yes, list the name of the drug, dose of the drug, and the approximate dates the drug was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF VYTORIN

21. Is the member currently taking or has the member previously taken Vytorin? ❑ Yes ❑ No

22. Has the member taken Vytorin for at least three consecutive months and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

    If yes, list the dose of Vytorin and the approximate dates Vytorin was taken in the space provided.

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

SECTION IV — 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

Continued

SECTION V — 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.