July 11, 2011: Retroactive for dates of service on and after July 1, 2011, simvastatin 80mg will remain a preferred drug. Page 7 of this *Update* has been revised to reflect the change in policy. The Preferred Drug List Quick Reference pharmacy data table was revised and posted to the ForwardHealth Portal on July 7, 2011, to reflect the change in policy. In addition, a change to the clinical criteria for proton pump inhibitor (PPI) drugs was made on page 9.
July 15, 2011: An additional revision has been made on pages 6 and 7 as a result of the retroactive policy change.
August 8, 2011: A clarification has been made on page 9 to the clinical criteria for non-preferred orally disintegrating PPI tablets.

ForwardHealth
Wisconsin serving you

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

Summer 2011 Preferred Drug List Review

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List effective for dates of service on and after July 1, 2011.

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List (PDL) effective for dates of service (DOS) on and after July 1, 2011, unless otherwise noted.

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

- Preferred Drug List Quick Reference.
- BadgerCare Plus Basic Plan Product List.
- BadgerCare Plus Benchmark Plan Product List.
- BadgerCare Plus Core Plan Brand Name Drugs Quick Reference.
- BadgerCare Plus Core Plan Product List.

This *Update* provides an overview of the major changes to certain drug classes but does not address all of the changes made in drug classes.

Prescriber Responsibilities for Prior Authorization for Drugs

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

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

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

For Benchmark Plan, Core Plan, and Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan. Providers may refer to the previously listed benefit

plan-specific resources on the Portal for a list of drugs covered by each benefit plan.

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

Pharmacy Provider Responsibilities for Prior Authorization for Drugs

Pharmacy providers should review the Preferred Drug List Quick Reference on the Pharmacy page in the Providers area of the Portal for the most current list of preferred and non-preferred drugs.

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

Pharmacies are required to submit the PA request using the submission option most appropriate for the drug. Pharmacy providers may submit PA requests using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or on paper by fax or mail.

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

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

For Benchmark Plan, Core Plan, and Basic Plan members, if a drug is a noncovered drug, claims for the drug may be submitted to BadgerRx Gold.

New Drug Classes

The colony stimulating factors drug class and the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) drug class will be added to the PDL on July 1, 2011.

Providers may refer to the Preferred Drug List Quick Reference on the Pharmacy page of the Portal for the preferred and non-preferred drugs in these classes.

Acne Agents

Brand name Differin will be added as a preferred drug (in addition to current preferred drugs) in the acne agents drug class for Standard Plan, Medicaid, and SeniorCare members. Generic adapalene will change from a preferred drug to a non-preferred drug.

Other generic acne agents are covered for Benchmark Plan, Core Plan, and Basic Plan members. Providers may refer to the benefit plan-specific covered product pharmacy data table on the Pharmacy page of the Portal for a list of drugs covered by each plan.

Analgesics, Opioids Long-Acting

Oxycontin will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Prior authorization will be required for Oxycontin for DOS on and after August 1, 2011. Pharmacy providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug (i.e., fentanyl transdermal, methadone, morphine ER, or Kadian) in the analgesics, opioids long-acting drug class or request PA for a non-preferred drug.

ForwardHealth will begin accepting PA requests for Oxycontin for Standard Plan, Medicaid, and SeniorCare members on and after August 1, 2011.

Oxycontin continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Antithrombotic Agents, Injectable

Brand name Lovenox will be added as a preferred drug (in addition to current preferred drugs) in the antithrombotic agents, injectable drug class for Standard Plan, Medicaid, and SeniorCare members. Generic enoxaparin will change from a preferred drug to a non-preferred drug.

Enoxaparin continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Antiemetics

Ondansetron solution will be a preferred drug with a diagnosis restriction. A diagnosis code must be indicated on claim submissions for ondansetron solution. The allowable diagnosis code is V44.1 (Artificial opening status, gastrostomy). Providers may refer to the Diagnosis Restricted Drugs pharmacy data table on the Pharmacy page of the Portal for the most current list of allowable diagnosis codes.

Prior authorization is required for ondansetron solution for use outside the approved diagnosis for Standard Plan, Medicaid, and SeniorCare members. To request PA for ondansetron solution for members who do not meet the diagnosis restriction, prescribers are required to complete the Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08), and submit the form with clinical documentation to the pharmacy where the prescription will be filled. Providers may refer to the Forms page of the Portal for a copy of the PA/DGA form and completion instructions.

Ondansetron solution is a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members for uses outside the diagnosis restriction. Members do not have appeal rights for noncovered drugs. Providers may refer to the benefit plan-specific product list on the Pharmacy page of the Portal for other covered antiemetic drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Bladder Relaxant Preparations

Enablex will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Prior authorization will be required for Enablex for DOS on and after August 1, 2011. Pharmacy providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug (e.g., oxybutynin, VesiCare) in the bladder relaxant preparations drug class or request PA for a non-preferred drug.

ForwardHealth will begin accepting PA requests for Enablex for Standard Plan, Medicaid, and SeniorCare members on and after August 1, 2011.

Enablex continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Effective for DOS on and after July 1, 2011, quantity limits will apply to certain bladder relaxant preparations. Providers may refer to the revised Quantity Limit Drugs and Diabetic Supplies pharmacy data table on the Pharmacy page of the Portal for the most current list of drugs for which a quantity limit applies.

Beta Blockers

Brand name Toprol XL will be added as a preferred drug (in addition to current preferred drugs) in the beta blockers drug class for Standard Plan, Medicaid, and SeniorCare members. Generic metoprolol ER will change from a preferred drug to a non-preferred drug.

Toprol XL is a brand name drug that is excluded from brand medically necessary PA requirements. Pharmacy providers may indicate National Council for Prescription Drug Program (NCPDP) Dispense as Written (DAW) code "6" on claims for drugs excluded from brand medically necessary PA requirements. Members pay the generic copayment, not the brand name copayment, for drugs for which ForwardHealth has indicated that a preferred, brand name drug is less costly than its non-preferred generic counterpart and DAW "6" is indicated on claims. For a list of drugs for which DAW "6" may be indicated on claims, providers may refer to the Preferred Drug List Quick Reference on the Pharmacy page of the Portal. Providers may refer to the

Online Handbook for more information about the DAW policy.

Metoprolol ER continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Colony Stimulating Factors

The colony stimulating factors drug class is a new drug class on the PDL. Colony stimulating factors will no longer be diagnosis restricted. A diagnosis code is no longer required on claims for colony stimulating factors.

Growth Hormone Drugs

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092 (06/11), and established criteria for coverage of growth hormone drugs for Standard Plan, Medicaid, and SeniorCare members. Providers may refer to Attachments 1 and 2 of this *Update* for the revised completion instructions and form.

Growth hormone drugs continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Beginning July 1, 2011, ForwardHealth will return PA requests for growth hormone drugs received on the PA/PDL for Growth Hormone Drugs form dated 03/09.

Serostim

ForwardHealth continues to cover Serostim with PA for Standard Plan, Medicaid, and SeniorCare members with a diagnosis of AIDS wasting disease or cachexia.

Prior authorization requests for Serostim must be submitted on the PA/PDL for Growth Hormone Drugs.

Zorbtive

ForwardHealth continues to cover Zorbtive with PA for Standard Plan, Medicaid, and SeniorCare members with a diagnosis of short bowel syndrome. Members are limited to a 28-day course of the drug to reduce dependence on intravenous parenteral nutrition. Clinical documentation, including medical records that demonstrate the medical need for Zorbtive, should be submitted with each PA request.

Prior authorization requests for Zorbtive must be submitted on the PA/PDL for Growth Hormone Drugs.

Allowable Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Pediatric members with growth failure or short stature associated with chronic renal insufficiency and growth hormone treatment is pre-transplant.
- Pediatric members with growth failure or short stature associated with growth hormone deficiency confirmed with growth hormone stimulation testing demonstrating a growth hormone response of less than 10 ng/mL.
- Pediatric members with growth failure or short stature associated with Noonan's syndrome.
- Pediatric members with growth failure or short stature associated with Prader Willi syndrome.
- Pediatric members with growth failure or short stature associated with short stature homeobox-containing (SHOX) gene deficiency.
- Pediatric members with growth failure or short stature associated with Turner syndrome.
- Pediatric members born small for gestational age who are 2 years of age or older with a height that remains two standard deviations below the mean for chronological age.
- Adult members with growth hormone deficiency confirmed with an appropriate growth hormone stimulation test.
- Pediatric and adult members with hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies.

ForwardHealth does not cover growth hormone drugs for members with the following conditions:

- Closed epiphyses.
- If the member's growth rate falls to less than 2 cm/year.

- Noncompliance.

Prior authorization requests submitted for these conditions will be returned as a noncovered service. Members do not have appeal rights for noncovered services.

Note: For adult members with growth hormone deficiency confirmed with an appropriate growth hormone stimulation test and pediatric and adult members with hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies, the previous bullets regarding returned PA requests do not apply.

For members 18 years of age or older, PA requests for growth hormone drugs must be submitted to ForwardHealth on paper. On PA requests for growth hormone drugs, include the appropriate clinical and medical documentation for the PA consultant to make a determination about the request. Documentation may include the following:

- Bone age results.
- Growth charts and growth percentiles.
- Growth plate results.
- Growth hormone stimulation test results.
- Imaging results.
- Lab testing.
- Medical office notes.

Noncovered Diagnosis

ForwardHealth will no longer cover growth hormone drugs for members with a diagnosis of idiopathic short stature (ISS). Idiopathic short stature is a growth failure or short stature not associated with growth hormone deficiency or disease state.

Prior authorization requests submitted for a diagnosis of ISS will be returned to providers and the drug will be a noncovered drug; however, current, approved PAs will be honored until their expiration date. Members do not have appeal rights for noncovered drugs.

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

The HIV/AIDS drug class is a new drug class on the PDL. Non-preferred drugs in the HIV/AIDS drug class will be grandfathered until the generic becomes available for Standard Plan, Medicaid, and SeniorCare members who are currently taking the drugs. After the generic becomes available, grandfathering of non-preferred HIV/AIDs drugs will end for all members.

Certain preferred, generic HIV/AIDS drugs are covered by the Benchmark Plan. Providers may refer to the BadgerCare Plus Benchmark Plan Product List for the most current list of covered drugs.

The Core Plan and the Basic Plan do not cover drugs in the HIV/AIDS drug class for Core Plan or Basic Plan members. Claims for HIV/AIDS drugs for Core Plan and Basic Plan members who are also enrolled in the Wisconsin AIDS/HIV Drug Assistance Program (ADAP) should be submitted to ADAP. Providers with questions may call ADAP at (800) 991-5532.

Note: Although the HIV/AIDS drug class is split into multiple subclasses on the Preferred Drug List Quick Reference, ForwardHealth monitors the subclasses as a single drug class. Members must experience a treatment failure on a preferred drug in any subclass before PA may be requested for a non-preferred drug in any subclass. For example, a member must experience a treatment failure on a preferred protease inhibitor drug before PA may be requested for a non-preferred fusion inhibitor drug.

Lipotropics, Fibric Acids

Fenofibrate will be a non-preferred drug that requires PA for Standard Plan, Medicaid, and SeniorCare members. Providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the lipotropics, fibric acids drug classes or request PA for a non-preferred drug.

Fenofibrate continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Lipotropics, Other

Vytorin will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Zetia continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members.

Zetia and Vytorin continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Note: Vytorin will be removed from the lipotropics, statins drug class on the PDL and included only in the lipotropics, other drug class.

Prior Authorization Requests

ForwardHealth has revised and renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Zetia, F-00279 (06/10). The form has been renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Zetia or Vytorin, F-00279 (06/11). Providers may refer to Attachments 3 and 4 for the revised completion instructions and form.

Beginning July 1, 2011, ForwardHealth will return PA requests for Zetia or Vytorin received on the PA/PDL for Step Therapy for Zetia form dated 06/10.

For DOS from July 1, 2011, through August 31, 2011, to allow time to transition members currently taking Vytorin, ForwardHealth may approve STAT-PA requests for Vytorin for members who are stabilized on the drug for a days' supply through August 31, 2011. For DOS on and after September 1, 2011, members' prescriptions should be switched to a preferred drug or PA may be requested for a non-preferred drug if it is medically appropriate.

Clinical Criteria for Zetia

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 (LDL) cholesterol level, and
- The member has taken a preferred statin drug 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.

Clinical Criteria for Vytorin

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

- The member is being treated for an elevated total cholesterol level, or
- The member is being treated for an elevated LDL cholesterol level, and
- The member is stabilized on Vytorin and achieving a measureable therapeutic response, or
- The member is stabilized on simvastatin plus Zetia as two separate drugs and achieving a measureable therapeutic response, and
- The member has a medical condition that prevents him or her from taking simvastatin plus Zetia as two separate drugs. Clinical reasons do not include member preference or member copayment.

~~*Vytorin 10/80 mg*~~

~~As a result of safety concerns, additional clinical documentation must be submitted with PA requests for Vytorin 10/80 mg. Providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the lipotropics, other drug class, or request PA for a non-preferred drug. Prior authorization requests for Vytorin 10/80 mg should be~~

~~submitted on the PA/DGA, with clinical information documenting the medical need for the strength of the drug.~~

Lipotropics, Statins

Vytorin will be removed from the lipotropics, statins drug class on the PDL and included only in the lipotropics, other drug class.

As a result of an association between 80 mg simvastatin and an increased risk of myopathy, the Food and Drug Administration (FDA) has announced safety changes that will restrict use of what is currently the highest approved dose of simvastatin.

Simvastatin 80 mg will remain a preferred drug. The FDA is recommending that no new members be prescribed 80 mg of simvastatin. Members who have been taking the dose for a year or more are recommended to continue taking it, provided they have not experienced any muscle toxicity. In addition, the FDA also states that the labeling will feature new contraindications and dose limitations for when simvastatin is taken with certain other medications.

~~Providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the lipotropics, statins drug class or request PA for a non-preferred drug. Prior authorization requests for simvastatin 80 mg should be submitted on the PA/DGA with clinical information documenting the medical need for the strength of the drug.~~

Migraine Agents, Other and Migraine Agents, Injectable

The migraine agents, triptans drug class will be split into two new drug classes, the migraine agents, other drug class and the migraine agents, injectable drug class.

The step therapy policy for migraine agents, triptans will be discontinued effective for DOS on and after July 1, 2011.

Prior Authorization Requests

ForwardHealth has revised and renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Migraine Agents, Triptans, F-00280 (06/10). The form has been renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, F-00280 (06/11). Providers may refer to Attachments 5 and 6 for the revised completion instructions and form.

Beginning July 1, 2011, ForwardHealth will return PA requests for migraine agents received on the PA/PDL for Step Therapy for Migraine Agents, Triptans form dated 06/10.

Clinical Criteria for Non-preferred Migraine Agents, Other

Clinical criteria for approval of a PA request for non-preferred oral triptan drugs are the following:

- The member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response, and
- The member has previously taken any dosage form of naratriptan and experienced an unsatisfactory therapeutic response.

Clinical Criteria for Non-Preferred Migraine Agents, Injectable

Sumatriptan injectable is the only preferred migraine agent, injectable drug. Providers are encouraged to write prescriptions for sumatriptan injectable first before requesting PA for a non-preferred injectable drug. Prior authorization requests for non-preferred migraine agent, injectable drugs must be submitted to ForwardHealth on paper.

Clinical criteria for approval of a PA request for non-preferred injectable triptan drugs are the following:

- The member has previously used sumatriptan injectable and experienced an unsatisfactory therapeutic response, and

- The member has a medical condition that prevents him or her from using sumatriptan injectable.

Clinical Criteria for Cambia

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

- The member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction, or
- There is a clinically significant drug interaction between another medication the member is taking and sumatriptan, and
- The member has previously taken any dosage form of naratriptan and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction, or
- There is a clinically significant drug interaction between another medication the member is taking and naratriptan, and
- The member has tried and failed or experienced a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs (NSAIDs). (The two preferred, generic NSAIDs taken cannot include ibuprofen or naproxen.)

Note: Members are required to try and fail sumatriptan and naratriptan and two preferred, generic NSAIDs (not including ibuprofen or naproxen) before a PA request may be approved for Cambia.

Pancreatic Enzymes

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

For Standard Plan, Medicaid, and SeniorCare members, providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug (i.e., Pancrelipase, Zenpep) in the pancreatic enzymes drug classes or request PA for a non-preferred drug.

For Core Plan members who have not previously taken Pancreaze, the drug will be a noncovered drug. Providers may refer to the BadgerCare Plus Core Plan Brand Name Drugs Quick Reference on the Pharmacy page of the Portal for a complete list of drugs covered by the Core Plan.

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

Proton Pump Inhibitors

Proton pump inhibitor (PPI) drugs will no longer be diagnosis restricted. A diagnosis code is no longer required on claims for PPI drugs.

Lansoprazole solutab 15 mg continues to be a non-preferred drug; however, PA will not be required for lansoprazole solutab 15 mg for members who are 12 years of age and younger. For members 13 years of age or older, PA is required. An age restriction no longer applies to Nexium 10 mg suspension or Nexium 20 mg suspension; therefore, PA is required for Nexium 10 mg suspension and Nexium 20 mg suspension regardless of the member's age.

Prior Authorization Requests

ForwardHealth has revised and renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs, F-11078 (03/10). The form has been renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets, F-11078 (06/11). In addition, ForwardHealth has created a new form for the PPI drug class, the Prior Authorization/Preferred Drug List for Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets, F-00433 (06/11). Providers may refer to Attachments 7 through 10 for the revised completion instructions and forms.

For dates of receipt on and after July 1, 2011, ForwardHealth will return PA requests for PPI drugs submitted on the PA/PDL for PPI Drugs form dated 03/10.

Clinical Criteria for Non-preferred Capsules and Tablets

Clinical criteria for approval of a PA request for non-preferred PPI capsules and tablets are the following:

- The member experienced an unsatisfactory therapeutic response to omeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with omeprazole, and
- The member experienced an unsatisfactory therapeutic response to pantoprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with pantoprazole, and
- The member experienced an unsatisfactory therapeutic response to rabeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with rabeprazole.

Note: Members are required to try and fail omeprazole, pantoprazole, *and* rabeprazole before a PA request may be approved for a non-preferred PPI capsule or tablet.

Clinical Criteria for Non-preferred Suspensions

Clinical criteria for approval of a PA request for non-preferred PPI suspensions are the following:

- The member has a swallowing condition that prevents him or her from swallowing a tablet or capsule, and
- The member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of omeprazole, or
- The member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of pantoprazole.

Note: Members are required to have a swallowing condition that prevents them from swallowing a tablet or capsule, and they are required to try and fail omeprazole or pantoprazole before a PA request may be approved for a non-preferred suspension.

Clinical Criteria for Non-preferred Orally Disintegrating Tablets

Clinical criteria for approval of a PA request for non-preferred PPI orally disintegrating tablets are the following:

- The member has a swallowing condition that prevents him or her from swallowing a tablet or capsule, and
- The member has a medical condition that prevents him or her from taking a PPI suspension. Clinical reasons that prevent members from taking a PPI suspension cannot include member preference.

OR

Clinical criteria for approval of a PA request for non-preferred PPI orally disintegrating tablets are the following:

- The member has a swallowing condition that prevents him or her from swallowing a tablet or capsule, and
- The member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of omeprazole, and
- The member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of pantoprazole.

Note: Members are required to have a swallowing condition that prevents them from swallowing a tablet or capsule, and they are required to try and fail omeprazole and pantoprazole before a PA request may be approved for a non-preferred orally disintegrating tablet.

Pulmonary Arterial Hypertension

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

For Standard Plan, Medicaid, and SeniorCare members, providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug (e.g., Adcirca) in the pulmonary arterial hypertension drug class or request PA for a non-preferred drug.

For Core Plan members who have not previously taken Revatio, the drug will be a noncovered drug. Providers should begin working with prescribers to switch a member's prescription if medically appropriate to a preferred drug (e.g., Adcirca) in the pulmonary arterial hypertension drug class. Providers may refer to the BadgerCare Plus Core Plan Brand Name Drug Quick Reference on the Pharmacy page of the Portal for a complete list of drugs covered by the Core Plan.

The drug class continues to be a noncovered drug class for Benchmark Plan and Basic Plan members.

Pulmonary arterial hypertension drugs continue to be diagnosis restricted.

Quantity limits will apply to Adcirca for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Providers may refer to the revised Quantity Limit Drugs and Diabetic Supplies on the Pharmacy page of the Portal for the most current list of drugs for which a quantity limit applies.

Expedited Emergency Supply Policy Changes

The colony stimulating factors drug class and the HIV/AIDS drug class will be added to the expedited emergency supply policy.

As a result, ForwardHealth has revised the Expedited Emergency Supply Request Drugs pharmacy data table. Providers may refer to the Pharmacy page on the Portal for the most current list of expedited emergency supply drugs.

Submitting Prior Authorization Requests

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

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

Prior authorization requests submitted on paper for non-preferred drugs in classes in this *Update* must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/08), unless otherwise indicated.

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

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

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

For PA requests submitted by fax or mail, the pharmacy provider is required to complete, physically sign, date, and submit to ForwardHealth a Prior Authorization Request Form (PA/RF), F-11018 (10/08), with the PA form and supporting documentation received from the prescriber.

Reminders

Preferred Drug List recommendations are made to the Wisconsin Medicaid Pharmacy PA Advisory Committee based on the therapeutic significance of individual drugs and the cost-effectiveness and supplemental rebates with drug manufacturers. Drugs to be included on the PDL are recommended to the PA Advisory Committee based on research from peer-reviewed medical literature, drug studies and trials, and clinical information prepared by clinical pharmacists. Drugs reviewed prior to PA Advisory Committee review are automatically added as non-preferred drugs to the PDL.

Before a non-preferred drug is prescribed, members are required to experience a treatment failure on at least one preferred drug in the same drug class as the non-preferred drug. For example, a member must experience a treatment failure on a preferred lipotropics, statin drug before PA may be requested for a non-preferred lipotropics, statin drug. Prior authorization could not be requested for a lipotropics, fibric acid drug if the member has only experienced a treatment failure on a lipotropics, statin drug. Clinical PA and drug-specific clinical criteria apply to certain drugs and drug classes.

If drugs change from a preferred to non-preferred status (i.e., colestipol) or vice versa, the status change may impact whether or not a drug is covered by the Benchmark Plan, the Core Plan, and the Basic Plan. Providers should refer to the following pharmacy data tables on the Pharmacy page of the Portal for the most current list of drugs covered by each benefit plan:

- BadgerCare Plus Basic Plan Product List.
- BadgerCare Plus Benchmark Plan Product List.
- BadgerCare Plus Core Plan Brand Name Drugs Quick Reference.
- BadgerCare Plus Core Plan Product List.

For More Information

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

Information Regarding Managed Care Organizations

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

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

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

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

P-1250

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, F-11092. Pharmacy providers are required to use the PA/PDL for Growth Hormone Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

2) For 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: For PA requests for Zorbtive, prescribers are required to complete only Section III of the form. Clinical documentation, including supporting medical records describing the medical need for Zorbtive should be included in Section VI of the form.

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 the 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 Growth Hormone Drugs 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
Check the box to indicate whether or not the member has a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) wasting disease or cachexia. Complete Section IIIB only if yes is checked in this element.

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS

Element 15
Check the box to indicate whether or not the drug requested is a preferred growth hormone drug. If the drug is a non-preferred growth hormone drug, describe the reason for the request in the space provided.

Element 16
Check the box to indicate whether or not the member is 17 years of age or younger.

Note: For members 18 years of age or older, PA requests for growth hormone drugs must be submitted to ForwardHealth on paper.

Element 17
Check the box to indicate whether or not the prescription is written by an endocrinologist. The prescription must be written by an endocrinologist for the member to begin treatment with a growth hormone drug.

Element 18
Check the box to indicate the condition(s) for which the growth hormone drug will be used.

Element 19
Check the box to indicate whether or not the member had a recent stimulated response growth hormone test. Indicate the type of the most recent stimulated response growth hormone test, the date of the test, and the test result. In the STAT-PA system, indicate the test result as a three-digit number (e.g., if the test result is 5.6 ng/mL, indicate “056” on the STAT-PA request). Indicate information about additional test results (e.g., type of test, date of test, test result) in the space provided.

Element 20
Include the appropriate clinical and medical documentation for the PA consultant to make a determination about the request. Documentation may include the following: bone age results; growth charts and growth percentiles; growth plate results; growth hormone stimulation test results; imaging results; lab testing; medical office notes. Clinical documentation must be attached to each PA request.

SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA
In Elements 21 through 24, prescribers should indicate "1" if the response to the question is yes. Indicate "2" if the response is no.

Element 21 — Diagnosis
The member must be at least 18 years of age and have a diagnosis of Human Immunodeficiency Virus to begin treatment with a growth hormone drug.

Element 22 — Member's Current Medical Condition
Indicate the member's current medical condition by responding to the clinical information listed in this section.

Element 23 — Evidence of Wasting Syndrome
The member must have either an unintentional weight loss of at least 10 percent or a gastrointestinal (GI) obstruction or malabsorption to qualify for treatment with a growth hormone drug.

Element 24
All of the clinical information listed must be tried and failed before a member may begin a course of therapy with a growth hormone drug.

SECTION IV — AUTHORIZED SIGNATURE

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 Growth Hormone Drugs form was signed (in MM/DD/CCYY format).

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

SECTION VI — 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 2
Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11092 (06/11)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions, F-11092A. 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 Growth Hormone Drugs signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system 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 a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) wasting disease or cachexia? (Complete Section IIIB only if yes is checked.) ❑ Yes ❑ No

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (Except for Serostim or Zorbtive.)

15. Is the drug requested a preferred growth hormone drug? ❑ Yes ❑ No

If the drug is a non-preferred growth hormone drug, describe the reason for the request in the space provided.

16. Is the member 17 years of age or younger? ❑ Yes ❑ No

17. Is the prescription for the growth hormone drug written by an endocrinologist? ❑ Yes ❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (Continued)

18. Indicate which of the following condition(s) the growth hormone drug is used for.

1. Noonan's syndrome.	❑ Yes	❑ No
2. Prader Willi syndrome.	❑ Yes	❑ No
3. Short stature homeobox-containing gene (SHOX) deficiency.	❑ Yes	❑ No
4. Turner syndrome.	❑ Yes	❑ No
5. Other. (Indicate condition.) _____	❑ Yes	❑ No

19. Does the member have a recent stimulated response growth hormone test? ❑ Yes ❑ No

Indicate the type of most recent stimulated response growth hormone test.

1. ❑ Arginine.
2. ❑ Clonidine.
3. ❑ Glucagon.
4. ❑ Growth hormone releasing hormone (GhRH).
5. ❑ Insulin.
6. ❑ L-Dopa.

Indicate the date of the test. ___ ___ (Month) ___ ___ ___ ___ (Year)
Indicate the test result. ___ ___. ___ ng/mL

Indicate information about additional test results (i.e., type of test, date of test, test result) in the space provided.

20. Additional documentation for PA requests for growth hormone drugs is required. Include the appropriate clinical and medical documentation for the PA consultant to make a determination about the request. Documentation may include the following: bone age results; growth charts and growth percentiles; growth plate results; growth hormone stimulation test results; imaging results; lab testing; medical office notes. Clinical documentation must be attached to each PA request.

Continued

SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA
(Only complete this section if the member has a diagnosis of AIDS wasting disease or cachexia.)

21. **Diagnosis** **Response (Indicate "1" for yes or "2" for no.)**

A) The member is 18 years of age or older. _____
B) The member has Human Immunodeficiency Virus (HIV) with serum antibodies to HIV. _____
C) The member is female and pregnant or lactating. _____

22. **Member's Current Medical Condition**

D) The member has signs or symptoms of AIDS or associated illnesses. _____
E) The member has untreated or suspected serious systemic infection. _____
F) The member has an active malignancy other than Kaposi's sarcoma. _____
G) The member is on approved anti-retroviral therapy. _____
H) The member has documented hypogonadism and is taking gonadal steroids. _____

23. **Evidence of Wasting Syndrome**

I) The member has unintentional weight loss of at least 10 percent from baseline. _____
J) The member has a gastrointestinal (GI) obstruction or malabsorption to account for weight loss. _____

Indicate the member's height (in inches). _____
Indicate the member's usual weight (in pounds) prior to diagnosis of HIV. _____
Indicate the member's current weight (in pounds). _____

24. **All of the following must be tried before beginning a course of therapy with a growth hormone drug**

K) The member is receiving at least 100 percent of estimated caloric requirement on current regimen. _____
L) The member has tried and failed a previous trial with megesterol acetate and / or dronabinal. _____
M) The member has completed a course of therapy of at least 24 weeks of protease inhibitors alone or with nucleosides. _____
N) The member has completed a course of therapy using dihydrotestosterone (when appropriate). _____

NEED LEVEL

Enter all 14 digits for this section in the following spaces. Do not include the measurements for the member's height, usual weight, or current weight.

___ ___ ___ — ___ ___ ___ ___ ___ — ___ ___ — ___ ___ ___ ___
A B C D E F G H I J K L M N

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — 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.)

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

Continued

SECTION VI — 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 3
Prior Authorization/Preferred Drug List (PA/PDL) for Zetia or Vytorin Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ZETIA OR VYTORIN 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 Zetia or Vytorin form, F-00279. Pharmacy providers are required to use the PA/PDL for Zetia or Vytorin 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 Zetia or Vytorin 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
Check the box to indicate whether or not the member is being treated for an elevated total cholesterol level.

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

SECTION IIIA — CLINICAL INFORMATION FOR ZETIA

Element 16
Check the box to 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
Check the box to indicate whether or not there is a clinically significant drug interaction with 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
Check the box to indicate whether or not the member is currently taking or has previously taken a statin drug.

Element 19
Check the box to 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
Check the box to 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, dose of the drug, and the approximate dates the drug was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR VYTORIN

Element 21
Check the box to indicate whether or not the member is stabilized on Vytorin and achieving a measureable therapeutic response.

Element 22
Check the box to indicate whether or not the member is stabilized on simvastatin plus Zetia as two separate drugs and achieving a measureable therapeutic response.

Element 23
Check the box to indicate whether or not the member has a medical condition(s) that prevents him or her from taking simvastatin plus Zetia as two separate drugs. If yes, list the medical condition(s) in the space provided.

Element 24
Check the box to indicate whether or not member preference or member copayment are reasons why the member is unable to take simvastatin plus Zetia as two separate drugs.

SECTION IV — AUTHORIZED SIGNATURE

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 Zetia or Vytorin form was signed (in MM/DD/CCYY format).

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

SECTION VI — 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 4
Prior Authorization/Preferred Drug List (PA/PDL) for Zetia or Vytorin

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00279 (06/11)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ZETIA OR VYTORIN

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Zetia or Vytorin 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 Zetia or Vytorin signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system 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. 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 ZETIA (Complete this section only for PA requests for Zetia.)

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 ZETIA (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 VYTORIN (Complete this section only for PA requests for Vytorin.)

21. Is the member stabilized on Vytorin and achieving a measureable therapeutic response? ❑ Yes ❑ No

22. Is the member stabilized on simvastatin plus Zetia as two separate drugs and achieving a measureable therapeutic response? ❑ Yes ❑ No

23. Does the member have a medical condition(s) that prevents him or her from taking simvastatin plus Zetia as two separate drugs? ❑ Yes ❑ No

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

24. Are member preference or member copayment the reasons why the member is unable to take simvastatin plus Zetia as two separate drugs? ❑ Yes ❑ No

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — 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.)

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

Continued

SECTION VI — 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 5
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MIGRAINE 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 Migraine Agents form, F-00280. Pharmacy providers are required to use the PA/PDL for Migraine 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 Migraine 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.

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED MIGRAINE AGENTS, OTHER

Element 14
Check the box to indicate whether or not the member has previously taken any dosage form of sumatriptan.

Element 15
Check the box to indicate whether or not the member has taken sumatriptan and experienced an unsatisfactory therapeutic response. If yes, list the approximate dates sumatriptan was taken in the space provided.

Element 16
Check the box to indicate whether or not the member has previously taken any dosage form of naratriptan.

Element 17
Check the box to indicate whether or not the member has taken naratriptan and experienced an unsatisfactory therapeutic response. If yes, list the approximate dates naratriptan was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED MIGRAINE AGENTS, INJECTABLE
Prior authorization requests for non-preferred migraine agent, injectable drugs must be submitted to ForwardHealth on paper.

Element 18
Check the box to indicate whether or not the member has used sumatriptan injectable and experienced an unsatisfactory therapeutic response. If yes, list the approximate dates sumatriptan injectable was used in the space provided.

Element 19
Check the box to indicate whether or not the member has a medical condition(s) that prevents the member from using sumatriptan injectable. If yes, list the medical condition(s) in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR CAMBIA

Element 20
Check the box to indicate whether or not the member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, list the dosage form and specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 21
Check the box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and sumatriptan. If yes, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

Element 22
Check the box to indicate whether or not the member has previously taken any dosage form of naratriptan and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, list the dosage form and specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 23
Check the box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and naratriptan. If yes, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

Element 24
Check the box to indicate whether or not the member has tried and failed or experienced a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs (NSAIDs). (The two preferred, generic NSAIDs taken cannot include ibuprofen or naproxen.) If yes, check the boxes to indicate the NSAIDs that were taken, and list specific details about the treatment failures or clinically significant adverse drug reactions and the approximate dates the two preferred, generic NSAIDs were taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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 Migraine Agents form was signed (in MM/DD/CCYY format).

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

SECTION VI — 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 6
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00280 (06/11)

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents 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 Migraine Agents signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system 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 NON-PREFERRED MIGRAINE AGENTS, OTHER (Except for Cambia.)

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

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

If yes, list the approximate dates sumatriptan was taken in the space provided.

16. Has the member previously taken any dosage form of naratriptan? ❑ Yes ❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED MIGRAINE AGENTS, OTHER (Continued)

17. Has the member taken naratriptan and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

    If yes, list the approximate dates naratriptan was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED MIGRAINE AGENTS, INJECTABLE (Complete this section only for PA requests for an injectable migraine agent.)

18. Has the member used sumatriptan injectable and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

    If yes, list the approximate dates sumatriptan injectable was used in the space provided.

19. Does the member have a medical condition(s) that prevents the member from using sumatriptan injectable? ❑ Yes ❑ No

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

SECTION IIIC — CLINICAL INFORMATION FOR CAMBIA (Complete this section only for PA requests for Cambia.)

20. Has the member previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, list the dosage form and specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

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

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

22. Has the member previously taken any dosage form of naratriptan and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, list the dosage form and specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

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

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

Continued

SECTION IIIC — CLINICAL INFORMATION FOR CAMBIA (Continued)

24. Has the member tried and failed or experienced a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs (NSAIDs)? (The two preferred, generic NSAIDs taken cannot include ibuprofen or naproxen.) ❑ Yes ❑ No

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

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

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

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — 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.)

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 VI — 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 7
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) CAPSULES AND TABLETS COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets form, F-11078. Pharmacy providers are required to use the PA/PDL for PPI Capsules and Tablets 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

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for PPI Capsules and Tablets 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
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response to omeprazole. If yes, list the approximate dates omeprazole was taken in the space provided.

Element 15
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with omeprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates omeprazole was taken in the space provided.

Element 16
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response to pantoprazole. If yes, list the approximate dates pantoprazole was taken in the space provided.

Element 17
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with pantoprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates pantoprazole was taken in the space provided.

Element 18
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response to rabeprazole. If yes, list the approximate dates rabeprazole was taken in the space provided.

Element 19
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with rabeprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates rabeprazole was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

Element 21 — Date Signed
Enter the month, day, and year the PA/PDL for PPI Capsules and Tablets form was signed (in MM/DD/CCYY format).

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

Element 24 — NPI
Enter the NPI.

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

SECTION VI — 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 8
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) CAPSULES AND TABLETS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets Completion Instructions, F-11078A. 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 Proton Pump Inhibitor (PPI) Capsules and Tablets signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system 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. Has the member experienced an unsatisfactory therapeutic response to omeprazole? ❑ Yes ❑ No

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

15. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with omeprazole? ❑ Yes ❑ No

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

Continued

SECTION III — CLINICAL INFORMATION (Continued)

16. Has the member experienced an unsatisfactory therapeutic response to pantoprazole? ❑ Yes ❑ No

    If yes, list the approximate dates pantoprazole was taken in the space provided.

17. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with pantoprazole? ❑ Yes ❑ No

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

18. Has the member experienced an unsatisfactory therapeutic response to rabeprazole? ❑ Yes ❑ No

    If yes, list the approximate dates rabeprazole was taken in the space provided.

19. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with rabeprazole? ❑ Yes ❑ No

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

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

24. NPI

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

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

27. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

31. Include any additional 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 Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) SUSPENSIONS AND ORALLY DISINTEGRATING TABLETS COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets form, F-00433. Pharmacy providers are required to use the PA/PDL for PPI Suspensions and Orally Disintegrating Tablets 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

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for PPI Suspensions and Orally Disintegrating Tablets 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 NON-PREFERRED SUSPENSIONS

Element 14
Check the box to indicate whether or not the member has a swallowing condition that prevents the member from swallowing a tablet or capsule. If yes, list the condition in the space provided.

Element 15
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole. If yes, list the approximate dates omeprazole was taken in the space provided.

Element 16
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of omeprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates omeprazole was taken in the space provided.

Element 17
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole. If yes, list the approximate dates pantoprazole was taken in the space provided.

Element 18
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of pantoprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates pantoprazole was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED ORALLY DISINTEGRATING TABLETS

Element 19
Check the box to indicate whether or not the member has a swallowing condition that prevents the member from swallowing a tablet or capsule. If yes, list the condition in the space provided.

Element 20
Check the box to indicate whether or not the member has a medical condition(s) that prevents the member from taking a PPI suspension. If yes, list the medical condition(s) in the space provided.

Element 21
Check the box to indicate whether or not member preference is the reason why the member is unable to take a PPI suspension.

Element 22
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole. If yes, list the approximate dates omeprazole was taken in the space provided.

Element 23
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of omeprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates omeprazole was taken in the space provided.

Element 24
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole. If yes, list the approximate dates pantoprazole was taken in the space provided.

Element 25
Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of pantoprazole. If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates pantoprazole was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

Element 27 — Date Signed
Enter the month, day, and year the PA/PDL for PPI Suspensions and Orally Disintegrating Tablets form was signed (in MM/DD/CCYY format).

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

Element 28 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 29 — Days' Supply Requested
Enter the requested days' supply.

Element 30 — NPI
Enter the NPI.

Element 31 — 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 32 — 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 33 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 34 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 35 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 36 — Number of Days Approved
Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 37
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 Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00433 (06/11)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) SUSPENSIONS AND ORALLY DISINTEGRATING TABLETS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets Completion Instructions, F-00433A. 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 Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system 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 NON-PREFERRED SUSPENSIONS

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

If yes, list the condition in the space provided.

Continued

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED SUSPENSIONS (Continued)

15. Has the member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole? ❑ Yes ❑ No

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

16. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of omeprazole? ❑ Yes ❑ No

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

17. Has the member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole? ❑ Yes ❑ No

If yes, list the approximate dates pantoprazole was taken in the space provided.

18. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of pantoprazole? ❑ Yes ❑ No

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

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED ORALLY DISINTEGRATING TABLETS

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

If yes, list the condition in the space provided.

20. Does the member have medical condition(s) that prevents the member from taking a PPI suspension? ❑ Yes ❑ No

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

21. Is member preference the reason why the member is unable to take a PPI suspension? ❑ Yes ❑ No

22. Has the member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole? ❑ Yes ❑ No

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

23. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of omeprazole? ❑ Yes ❑ No

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

Continued

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED ORALLY DISINTEGRATING TABLETS (Continued)

24. Has the member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole? ❑ Yes ❑ No

If yes, list the approximate dates pantoprazole was taken in the space provided.

25. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of pantoprazole? ❑ Yes ❑ No

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

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

30. NPI

31. 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.)

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

33. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

37. 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.