ForwardHealth
Wisconsin serving you

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

Spring 2012 Pharmacy Policy Changes

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about pharmacy policy changes, some changes effective for dates of service (DOS) on and after March 15, 2012, and others effective for DOS on and after April 1, 2012.

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For information about covered drugs, providers may refer to the following benefit plan-specific pharmacy data tables on the Pharmacy page of 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.

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, signed, and dated 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 that 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 of 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, on the Portal, or on paper by fax or mail.

Pharmacy providers are required to retain a completed, signed, and dated 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.

Antidepressants, SSRI

Effective for DOS on and after April 1, 2012, the following selective serotonin reuptake inhibitor (SSRI) antidepressant drugs will be added to the Three Month Supply data table as drugs that may be dispensed in up to a three-month supply:

- Citalopram.
- Fluoxetine.
- Sertraline.

Providers may refer to the Pharmacy page of the Providers area of the Portal for the revised data table. The Drugs with a Three-Month Supply Maximum topic (topic #1939) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook includes more information about the three-month supply of drugs policy.

Cymbalta

A step therapy PA continues to apply to Cymbalta. In addition, Cymbalta continues to be a non-preferred drug in the antidepressants, other and in the fibromyalgia Preferred Drug List (PDL) drug classes.

Cymbalta continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members; however, for Core Plan members who were grandfathered on Cymbalta, effective for DOS on and after July 1, 2009, Cymbalta continues to be covered.

Prior Authorization Requests for Cymbalta for Chronic Musculoskeletal Pain

ForwardHealth has created a new form, the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain, F-00582 (03/12), and established clinical criteria for coverage of Cymbalta for chronic musculoskeletal pain. Prior authorization requests for Cymbalta for chronic musculoskeletal pain may be submitted on the PA/PDL for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain effective for DOS on and after March 15, 2012. Providers may refer to Attachments 1 and 2 of this *Update* for a copy of the completion instructions and form.

Clinical Criteria for Cymbalta for Chronic Musculoskeletal Pain

Clinical criteria for approval of a PA request for Cymbalta for chronic musculoskeletal pain are both of the following:

- The member must have a diagnosis of chronic musculoskeletal pain.
- The member has experienced an unsatisfactory therapeutic response, clinically significant adverse drug reaction, clinically significant drug interaction, or has been diagnosed with a medical condition that prevents the use of all of the following:
  - ✓ Acetaminophen or acetaminophen in combination with an opioid analgesic.
  - ✓ Two or more preferred nonsteroidal anti-inflammatory drugs.
  - ✓ One or more preferred skeletal muscle relaxant.

Prior Authorization Requests for Cymbalta for Major Depressive Disorder

ForwardHealth has revised the clinical criteria for major depressive disorder (MDD). As a result of the clinical criteria changes, ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD), F-00284 (03/12), completion instructions and form. Providers may refer to Attachments 3 and 4 for a copy of the revised completion instructions and form.

Prior authorization requests for Cymbalta for MDD received by ForwardHealth on and after March 15, 2012, must be submitted on the revised PA/PDL for Step Therapy for Cymbalta for MDD dated 03/12. ForwardHealth will return PA requests for Cymbalta for MDD received on and after March 15, 2012, using the PA/PDL for Step Therapy for MDD dated 10/11.

Clinical Criteria for Cymbalta for Major Depressive Disorder

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

- The member has a diagnosis of MDD.
- The member has previously taken a preferred SSRI drug for MDD and one of the following:
  - ✓ Experienced an unsatisfactory therapeutic response.
  - ✓ Experienced a clinically significant adverse drug reaction.
- The member has taken any formulation of bupropion or venlafaxine for MDD and one of the following:
  - ✓ Experienced an unsatisfactory therapeutic response.
  - ✓ Experienced a clinically significant adverse drug reaction.

Members must try and fail a preferred SSRI drug and any formulation of bupropion or venlafaxine before PA may be requested for Cymbalta; however, if the member is currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response and the member has not taken drug company-provided samples of Cymbalta in the past 30 days, PA requests for Cymbalta may be approved.

Additional Prior Authorization Forms for Cymbalta

Prior authorization requests for Cymbalta may also be submitted on one of the following forms:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Diabetic Peripheral Neuropathy (DPN), F-00285 (10/11).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Fibromyalgia, F-00282 (10/11).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD), F-00283 (10/11).

These forms have not been revised.

As a reminder, PA requests for Cymbalta must be submitted on the most appropriate PA/PDL for Step Therapy for Cymbalta form. If Cymbalta is being prescribed for more than one indication, providers should complete and submit the PA form most appropriate to the primary indication.

Hepatitis C Agents

Incivek and Victrelis continue to be preferred hepatitis C agents on the PDL that require clinical PA for Standard Plan, Core Plan, Medicaid, and SeniorCare members.

Incivek and Victrelis continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

On April 1, 2012, ForwardHealth will remove hepatitis C agents from the Expedited Emergency Supply Request Drugs data table. Providers may refer to the Pharmacy page of the Providers area of the Portal for the revised data table. Providers may dispense an emergency supply of a hepatitis C agent and submit a Noncompound Drug Claim, F-13072 (09/11), with a Pharmacy Special Handling Request, F-13074 (04/11), for reimbursement. The Emergency Medication Dispensing topic (#1399) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of Pharmacy service area of the Online Handbook includes more information about dispensing an emergency supply of medication.

Clinical Criteria for Incivek and Victrelis

ForwardHealth has revised the clinical criteria for Incivek and Victrelis. Clinical criteria for approval of a PA request for Incivek and Victrelis are all of the following:

- The member has a diagnosis of chronic hepatitis C with genotype 1 hepatitis C virus (HCV).
- The member is 18 years of age or older.
- The member is not pregnant.
- The member has not had a liver transplant.
- The member has not received a prior course of therapy with a treatment regimen that includes the requested agent or any other HCV NS3/4A protease inhibitor.
- The member's treatment includes concurrent use of pegylated interferon and ribavirin.
- The member has compensated liver disease.
- The member is not taking any contraindicated drugs.

Clinical Criteria for Victrelis

For PA requests for Victrelis, in addition to the previously listed clinical criteria, the member's treatment must include a four-week lead-in period with pegylated interferon and ribavirin before starting Victrelis therapy.

Documentation Requirements

All clinical criteria must be documented on the PA requests for Incivek and Victrelis. In addition, the following must also be documented on the PA request:

- For initial PA requests, the initial hepatitis C virus ribonucleic acid (HCV-RNA) level before therapy began and the date the level was obtained.
- For renewal PA requests for Incivek, the HCV-RNA level at treatment week 4 and the date the level was obtained.
- For renewal PA requests for Victrelis, the HCV-RNA level and the date the level was obtained at the following appropriate intervals indicated in the Victrelis Response-Guided Therapy (RGT) guidelines:
  - ✓ Treatment week 8 (i.e., at 4 weeks taking Victrelis) (for members who are naïve to treatment with pegylated interferon and ribavirin prior to current treatment with Victrelis).
  - ✓ Treatment week 12 (i.e., at 8 weeks taking Victrelis).
  - ✓ Treatment week 24 (i.e., at 20 weeks taking Victrelis).

If the member is coinfected with hepatitis B or Human Immunodeficiency Virus, prescribers are required to document the following on PA requests for Incivek and Victrelis:

- The prescriber's medical specialty.
- The prescriber's experience with prescribing and managing HCV NS3/4 protease inhibitors in coinfected members.
- Why treatment with an HCV NS3/4 protease inhibitor is clinically appropriate for the member.

Prior Authorization Requests

For Incivek, initial PA requests may be approved for up to a maximum of eight weeks. Prior authorization requests may be renewed for up to an additional four weeks if the member's HCV-RNA is 1,000 IU/ml or less at treatment week 4. Treatment with Incivek may be approved for up to a

maximum treatment period of 12 weeks. Treatment with Incivek should be discontinued at treatment week 4 if the member's HCV-RNA is greater than 1,000 IU/ml.

If treatment with pegylated interferon or ribavirin is discontinued for any reason, treatment with Incivek must be discontinued.

For Victrelis, initial PA requests may be approved for up to a maximum of 12 weeks. Prior authorization requests may be renewed for up to an additional 12 weeks if the member's HCV-RNA is less than 100 IU/ml at treatment week 12 (i.e., at 8 weeks taking Victrelis). A final renewal request may be approved for up to an additional 20 weeks if the member's HCV-RNA is undetectable at treatment week 24 (i.e., at 20 weeks taking Victrelis). Treatment with Victrelis may be approved for up to a maximum period of 44 weeks. The maximum approval period for PA requests for Victrelis is based on the Victrelis RGT guidelines. If the member's HCV-RNA is greater than or equal to 100 IU/ml at treatment week 12 or if the member's HCV-RNA is detectable at treatment week 24, treatment with Victrelis should be discontinued.

If treatment with pegylated interferon or ribavirin is discontinued for any reason, treatment with Victrelis must be discontinued.

Submitting Prior Authorization Requests

Effective for DOS on and after April 1, 2012, PA requests for Incivek and Victrelis must be submitted on the new Prior Authorization Drug Attachment for Incivek and Victrelis, F-00583 (03/12). Providers may refer to Attachments 5 and 6 for a copy of the form and completion instructions.

Prior authorization requests for Incivek and Victrelis may be submitted electronically on the Portal or on paper by fax or mail. ForwardHealth will make a decision about PA requests for Incivek and Victrelis within one business day of receipt of all necessary information.

Note: For DOS on and after April 1, 2012, ForwardHealth will no longer accept PA requests for Incivek and Victrelis that are submitted on the Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08).

The Prior Authorization Drug Attachment for Incivek and Victrelis should be completed for initial PA requests *and* renewal PA requests.

For initial PA requests for Incivek or Victrelis, prescribers should complete Sections I, II, III, and VI of the Prior Authorization Drug Attachment for Incivek and Victrelis and submit the form to the pharmacy where the prescription will be filled. Pharmacy providers are required to submit to ForwardHealth the completed Prior Authorization Drug Attachment for Incivek and Victrelis and a completed Prior Authorization Request Form (PA/RF), F-11018 (10/08), for initial PA requests.

For renewal PA requests for Incivek and Victrelis, prescribers are required to complete Sections I, II, IV or V, and VI of the Prior Authorization Drug Attachment for Incivek and Victrelis form and submit the form to the pharmacy where the prescription will be filled. Pharmacy providers are required to submit to ForwardHealth the completed Prior Authorization Drug Attachment for Incivek and Victrelis and a completed Prior Authorization Amendment Request, F-11042 (10/08), for renewal PA requests.

Hypoglycemics, GLP-1 Agents

Byetta and Victoza continue to be non-preferred drugs in the hypoglycemics, GLP-1 agents drug class. Effective for DOS on and after March 15, 2012, PA requests for Byetta and Victoza must be submitted on revised and renamed Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents, F-00238 (03/12). Providers may refer to Attachments 7 and 8 for a copy of the revised form and completion instructions.

Prior authorization requests for Byetta may be submitted using the STAT-PA system, on the Portal, or on paper by fax or mail.

Prior authorization requests for Victoza must be submitted on the Portal or on paper by fax or mail. Prior authorization requests for Victoza cannot be submitted using the STAT-PA system.

Byetta and Victoza continue to be covered drugs for Standard Plan, Medicaid, and SeniorCare members. Byetta and Victoza continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Byetta and Victoza continue to be diagnosis-restricted drugs. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page of the Providers area of the Portal for the most current list of diagnosis-restricted drugs.

Clinical Criteria for GLP-1 Agents

ForwardHealth has revised the clinical criteria for GLP-1 agents. Clinical criteria for approval of a PA request for GLP-1 agents are all of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is not currently being treated with insulin other than Lantus insulin.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member's hemoglobin (HbA1c) was measured within the past six months.
- If the member is not currently using a GLP-1 agent, his or her most recent HbA1c is 6.5 percent or greater.
- If the member is not being treated with Lantus insulin, one of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
  - ✓ The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
  - ✓ The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea, or
- If the member is being treated with Lantus insulin, one of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin.
  - ✓ The member is unable to take the maximum effective dose of metformin.

Prior authorization requests for GLP-1 agents may be initially approved for up to six months. Prior authorization requests may be approved for up to one year if the member has been using a GLP-1 agent for at least six months and the member's HbA1c decreases by at least 0.5 percent from the member's initial HbA1c or if the member's HbA1c was above seven percent and the HbA1c drops below seven percent. For ongoing PA renewal requests, the member must continue to maintain the improved HbA1c value.

Clinical Criteria for Victoza

For PA requests for Victoza, members must meet the above clinical criteria for GLP-1 agents and try and fail on the maximum dose of Byetta.

Prior authorization is required for Victoza and it will not be approved if the member is using any insulin, including

Lantus insulin. Only members who are not taking insulin may qualify for Victoza.

Submitting Prior Authorization Requests

Pharmacy providers may submit PA requests for non-preferred drugs in classes in this *Update* via the following:

- The STAT-PA system.
- The Portal.
- Fax
- Mail.

For PA requests submitted using the STAT-PA system, pharmacy 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 the appropriate PA form. Prescribers are required to send the appropriate PA form along with any supporting documentation to the pharmacy where the prescription will be filled. Prescribers and pharmacy providers are required to keep a completed copy of the PA form and any supporting documentation.

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 and submit to ForwardHealth a PA/RF with the PA attachment and supporting documentation received from the prescriber.

For More Information

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

Information Regarding Managed Care Organizations

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

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR CHRONIC MUSCULOSKELETAL PAIN COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain, F-00582. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

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

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

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

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

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

Note: A step therapy policy applies for Cymbalta. Members must try and fail on treatment with acetaminophen, two or more preferred nonsteroidal anti-inflammatory drugs, and one or more preferred skeletal muscle relaxants.

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
This element is populated with Cymbalta.

Element 5 — Drug Strength
Enter the strength of the drug listed in Element 4.

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

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

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

Element 14
Indicate whether or not the member has a diagnosis of chronic musculoskeletal pain.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF ACETAMINOPHEN

Element 15
Indicate whether or not the member has previously taken acetaminophen alone or in combination with an opioid analgesic for chronic musculoskeletal pain and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates acetaminophen was taken in the space provided.

Element 16
Indicate whether or not the member has a medical condition or if there is a clinically significant drug interaction that prevents him or her from using acetaminophen. If yes, indicate the member's medical condition or a description of the clinically significant drug interaction that prevents him or her from using acetaminophen in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

Element 17
Indicate whether or not the member has previously taken two or more preferred nonsteroidal anti-inflammatory drugs (NSAIDs) for chronic musculoskeletal pain and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred NSAIDs were taken on the lines provided on the form. In addition, list the names of the two preferred NSAIDs the member has taken on the lines provided on the form.

Element 18
Indicate whether or not the member has a medical condition or if there is a clinically significant drug interaction that prevents him or her from using NSAIDs. If yes, indicate the member's medical condition or a description of the clinically significant drug interaction that prevents him or her from using NSAIDs in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED SKELETAL MUSCLE RELAXANTS

Element 19
Indicate whether or not the member has previously taken one or more preferred skeletal muscle relaxants for chronic musculoskeletal pain and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred skeletal muscle relaxant was taken on the line provided on the form. In addition, list the name of the preferred skeletal muscle relaxant the member has taken on the line provided on the form.

Element 20
Indicate whether or not the member has a medical condition or if there is a clinically significant drug interaction that prevents him or her from using skeletal muscle relaxants. If yes, indicate the member's medical condition or a description of the clinically significant drug interaction that prevents him or her from using skeletal muscle relaxants in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

Element 25 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

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

Element 27 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

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

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

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

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

SECTION VI — ADDITIONAL INFORMATION

Element 32
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR CHRONIC MUSCULOSKELETAL PAIN

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain Completion Instructions, F-00582A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Chronic Musculoskeletal Pain form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Does the member have a diagnosis of chronic musculoskeletal pain? ❑ Yes ❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF ACETAMINOPHEN

15. Has the member previously taken acetaminophen alone or in combination with an opioid analgesic for chronic musculoskeletal pain and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates acetaminophen was taken in the space below.

16. Does the member have a medical condition or is there a clinically significant drug interaction that prevents him or her from using acetaminophen? ❑ Yes ❑ No

    If yes, indicate the member's medical condition or a description of the clinically significant drug interaction that prevents him or her from using acetaminophen in the space below.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

17. Has the member previously taken two or more preferred nonsteroidal anti-inflammatory drugs (NSAIDs) for chronic musculoskeletal pain and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred NSAIDs were taken on the lines below.

    If yes, list the names of the two preferred NSAIDs the member has taken.

    1. _____

    2. _____

18. Does the member have a medical condition or is there a clinically significant drug interaction that prevents him or her from using NSAIDs? ❑ Yes ❑ No

    If yes, indicate the member's medical condition or a description of the clinically significant drug interaction that prevents him or her from using NSAIDs in the space below.

SECTION IIIC — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED SKELETAL MUSCLE RELAXANTS

19. Has the member previously taken one or more preferred skeletal muscle relaxants for chronic musculoskeletal pain and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred skeletal muscle relaxant was taken on the line below.

    If yes, list the name of a preferred skeletal muscle relaxant the member has taken.

    _____

20. Does the member have a medical condition or is there a clinically significant drug interaction that prevents him or her from using skeletal muscle relaxants? ❑ Yes ❑ No

    If yes, indicate the member's medical condition or a description of the clinically significant drug interaction that prevents him or her from using skeletal muscle relaxants in the space below.

Continued

SECTION IV — AUTHORIZED SIGNATURE	
21. **SIGNATURE** — Prescriber	22. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA	
23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 365 Days)

25. NPI

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

27. Place of Service

28. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) Completion Instructions

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

FORWARDHEALTH

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

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD), F-00284. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for MDD form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

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

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

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

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

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

Note: A step therapy policy applies for Cymbalta. Members must try and fail a preferred selective serotonin reuptake inhibitor (SSRI) drug and any formulation of bupropion or venlafaxine before PA may be requested for Cymbalta.

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
This element is populated with Cymbalta.

Element 5 — Drug Strength
Enter the strength of the drug listed in Element 4.

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

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

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

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

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

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

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

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF BUPROPION OR VENLAFAXINE

Element 17
Indicate whether or not the member has taken any formulation of bupropion for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates bupropion was taken in the space provided.

Element 18
Indicate whether or not the member has taken any formulation of venlafaxine for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates venlafaxine was taken in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR CURRENT USE OF CYMBALTA

Element 19
Indicate whether or not the member is currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response.

Element 20
Indicate whether or not the member has taken drug company-provided samples of Cymbalta in the past 30 days.

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

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

Element 25 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

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

Element 27 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

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

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

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

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

SECTION V — ADDITIONAL INFORMATION

Element 32
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD)

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00284 (03/12)

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) Completion Instructions, F-00284A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

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

Continued

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

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

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

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

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

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF BUPROPION OR VENLAFAXINE

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

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

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

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

SECTION IIIC — CLINICAL INFORMATION FOR CURRENT USE OF CYMBALTA

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

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

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

25. NPI

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

27. Place of Service

Continued

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

28. Assigned PA Number

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

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 5
Prior Authorization Drug Attachment for Incivek and Victrelis Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Incivek and Victrelis Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR INCIVEK AND VICTRELIS 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

Prescriber Responsibilities for Initial Prior Authorization Requests

For initial PA requests, prescribers should do the following:

- Complete **Sections I, II, III, and VI** of the Prior Authorization Drug Attachment for Incivek and Victrelis, F-00583.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Prescriber Responsibilities for Renewal Prior Authorization Requests

For renewal PA requests, prescribers should do the following:

- Complete **Sections I, II, IV or V, and VI** of the Prior Authorization Drug Attachment for Incivek and Victrelis.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Pharmacy Provider Responsibilities for Initial Prior Authorization Requests

For initial PA requests, pharmacy providers should do the following:

- Complete a Prior Authorization Request Form (PA/RF), F-11018.
- Submit the completed Prior Authorization Drug Attachment for Incivek and Victrelis with the PA/RF to ForwardHealth on the Portal or on paper by fax or mail.

Pharmacy Provider Responsibilities for Renewal Prior Authorization Requests

For renewal PA requests, pharmacy providers should do the following:

- Complete a Prior Authorization Amendment Request, F-11042.
- Submit the completed Prior Authorization Drug Attachment for Incivek and Victrelis with the Prior Authorization Amendment Request to ForwardHealth on the Portal or on paper by fax or mail.

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Pharmacy providers may submit PA requests on the Prior Authorization Drug Attachment for Incivek and Victrelis form in one of the following ways:

1) For paper PA requests by fax, pharmacy providers should submit a either a PA/RF for initial PA requests or a Prior Authorization Amendment Request for renewal PA requests and the Prior Authorization Drug Attachment for Incivek and Victrelis form to ForwardHealth at (608) 221-8616.

2) For paper PA requests by mail, pharmacy providers should submit a PA/RF for initial PA requests or a Prior Authorization Amendment Request for renewal PA requests and the Prior Authorization Drug Attachment for Incivek and Victrelis 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).

Prescribers and pharmacy providers are required to retain a completed copy of the form.

SECTION I — MEMBER INFORMATION — INITIAL AND RENEWAL REQUESTS

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 — INITIAL AND RENEWAL REQUESTS

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION FOR INCIVEK AND VICTRELIS — INITIAL REQUESTS ONLY

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Incivek and Victrelis form.

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

Element 14
Indicate the member's hepatitis C genotype in the space provided.

Element 15
Indicate whether or not the member is 18 years of age or older.

Element 16
Indicate whether or not the member is pregnant.

Element 17
Indicate whether or not the member has had a liver transplant.

Element 18
Indicate whether or not the member has received a prior course of therapy with a treatment regimen that includes the requested agent or any other hepatitis C virus (HCV) NS3/4 protease inhibitor. If yes, indicate the specific details about the prior course of therapy, the drug name(s), the approximate dates of the prior course of treatment, why treatment was discontinued, and why another course of treatment is being requested in the space provided.

Element 19
Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was measured in the space provided.

Element 20
Indicate whether or not the member is currently being treated with pegylated interferon and ribavirin. If yes, indicate the date treatment with pegylated interferon and ribavirin started in the space provided. If no, indicate the date treatment with pegylated interferon and ribavirin is anticipated to start in the space provided.

Element 21
For Victrelis requests only, indicate the date treatment with Victrelis is anticipated to start in the space provided.

Element 22
Indicate whether or not the member has previous treatment experience with pegylated interferon and ribavirin. If yes, indicate the member's previous treatment experience with pegylated interferon and ribavirin by checking one of the options listed. If the member did not complete the full course of treatment, indicate the reason why in the space provided.

Element 23
Indicate whether or not the member is coinfected with hepatitis B.

Element 24
Indicate whether or not the member is coinfected with Human Immunodeficiency Virus (HIV).

Element 25
If the member is coinfected with hepatitis B or HIV, indicate the prescriber's medical specialty and experience with prescribing and managing HCV NS3/4 protease inhibitors in coinfected members and why treatment with a HCV NS3/4 protease inhibitor is clinically appropriate for the member in the space provided.

RENEWAL PRIOR AUTHORIZATION REQUESTS FOR INCIVEK AND VICTRELIS

SECTION IV — CLINICAL INFORMATION FOR INCIVEK — RENEWAL REQUESTS ONLY

Element 26
Indicate the member's HCV-RNA level at treatment week 4 and the date it was measured in the spaces provided.

SECTION V — CLINICAL INFORMATION FOR VICTRELIS — RENEWAL REQUESTS ONLY

Element 27
Indicate the member's HCV-RNA level at treatment week 12 (i.e., at 8 weeks taking Victrelis) and the date it was measured in the spaces provided.

Element 28
Indicate the member's HCV-RNA level at treatment week 24 (i.e., at 20 weeks taking Victrelis) and the date it was measured in the spaces provided.

Element 29
Indicate whether or not the member was naïve to treatment with pegylated interferon and ribavirin prior to current treatment regimen with Victrelis. If yes, indicate the member's HCV-RNA level at treatment week 8 (i.e., at 4 weeks taking Victrelis) and the date it was measured in the space provided.

SECTION VI — AUTHORIZED SIGNATURE — INITIAL AND RENEWAL REQUESTS

Element 30 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 31 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VII — ADDITIONAL INFORMATION — INITIAL AND RENEWAL REQUESTS

Element 32
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 6
Prior Authorization Drug Attachment for Incivek and Victrelis

(A copy of the "Prior Authorization Drug Attachment for Incivek and Victrelis" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR INCIVEK AND VICTRELIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Incivek and Victrelis Completion Instructions, F-00583A. 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 Drug Attachment for Incivek and Victrelis form signed and dated by the prescriber before submitting a prior authorization (PA) request. Providers may call Provider Services at (800) 947-9627 with questions.

This form must be completed for initial PA requests *and* renewal PA requests.

Prescriber Responsibilities for Initial Prior Authorization Requests
For initial PA requests, prescribers should do the following:

- Complete **Sections I, II, III, and VI** of this form.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Prescriber Responsibilities for Renewal Prior Authorization Requests
For renewal PA requests, prescribers should do the following:

- Complete **Sections I, II, IV or V, and VI** of this form.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Pharmacy Provider Responsibilities for Initial Prior Authorization Requests
For initial PA requests, pharmacy providers should do the following:

- Complete a Prior Authorization Request Form (PA/RF), F-11018.
- Submit the completed Prior Authorization Drug Attachment for Incivek and Victrelis with the PA/RF to ForwardHealth on the Portal or on paper by fax or mail.

Pharmacy Provider Responsibilities for Renewal Prior Authorization Requests
For renewal PA requests, pharmacy providers should do the following:

- Complete a Prior Authorization Amendment Request, F-11042.
- Submit the completed Prior Authorization Drug Attachment for Incivek and Victrelis with the Prior Authorization Amendment Request to ForwardHealth on the Portal or on paper by fax or mail.

SECTION I — MEMBER INFORMATION — INITIAL AND RENEWAL REQUESTS

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

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

SECTION II — PRESCRIPTION INFORMATION — INITIAL AND RENEWAL REQUESTS

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

8. Directions for Use

Continued

SECTION II — PRESCRIPTION INFORMATION — INITIAL AND RENEWAL REQUESTS (Continued)

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR INCIVEK AND VICTRELIS — INITIAL REQUESTS ONLY

13. Diagnosis Code and Description

14. Indicate the member's hepatitis C genotype in the space below.

15. Is the member 18 years of age or older? ❑ Yes ❑ No

16. Is the member pregnant? ❑ Yes ❑ No

17. Has the member had a liver transplant? ❑ Yes ❑ No

18. Has the member received a prior course of therapy with a treatment regimen that includes the requested agent or any other hepatitis C virus (HCV) NS3/4 protease inhibitor? ❑ Yes ❑ No

If yes, indicate the specific details about the prior course of therapy, the drug name(s), the approximate dates of the prior course of treatment, why treatment was discontinued, and why another course of treatment is being requested in the space below.

19. Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

20. Is the member currently being treated with pegylated interferon and ribavirin? ❑ Yes ❑ No

If yes, indicate the date treatment with pegylated interferon and ribavirin started. _____

If no, indicate the date treatment with pegylated interferon and ribavirin is anticipated to start _____

21. For Victrelis requests only, indicate the date treatment with Victrelis is anticipated to start. _____

22. Has the member had previous treatment experience with pegylated interferon and ribavirin? ❑ Yes ❑ No

If yes, indicate the member's previous treatment experience by checking one of the following:

- ❑ Member did not achieve a response (null responder) during treatment with pegylated interferon and ribavirin.
- ❑ Member achieved a partial response to treatment with pegylated interferon and ribavirin.
- ❑ Member relapsed (experienced reappearance of serum HCV-RNA after achieving an undetectable level at the conclusion of a course of therapy with pegylated interferon and ribavirin).
- ❑ Member did not complete the full course of treatment.

If the member did not complete the full course of treatment, indicate the reason why in the space below.

Continued

SECTION III — CLINICAL INFORMATION FOR INCIVEK AND VICTRELIS — INITIAL REQUESTS ONLY (Continued)

23. Is the member coinfected with hepatitis B? ❑ Yes ❑ No

24. Is the member coinfected with Human Immunodeficiency Virus (HIV)? ❑ Yes ❑ No

25. If the member is coinfected with hepatitis B or HIV, indicate the prescriber's medical specialty and experience with prescribing and managing HCV NS3/4 protease inhibitors in coinfected members and why treatment with a HCV NS3/4 protease inhibitor is clinically appropriate for the member in the space below.

RENEWAL PRIOR AUTHORIZATION REQUESTS FOR INCIVEK AND VICTRELIS

SECTION IV — CLINICAL INFORMATION FOR INCIVEK — RENEWAL REQUESTS ONLY

26. Indicate the member's HCV-RNA level at treatment week 4 and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

SECTION V — CLINICAL INFORMATION FOR VICTRELIS — RENEWAL REQUESTS ONLY

27. Indicate the member's HCV-RNA level at treatment week 12 (i.e., at 8 weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

28. Indicate the member's HCV-RNA level at treatment week 24 (i.e., at 20 weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

29. Prior to the current treatment regimen with Victrelis, was the member naïve to treatment with pegylated interferon and ribavirin? ❑ Yes ❑ No

If yes, indicate the member's HCV-RNA level at treatment week 8 (i.e., at 4 weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

SECTION VI — AUTHORIZED SIGNATURE — INITIAL AND RENEWAL REQUESTS

30. **SIGNATURE** — Prescriber	31. Date Signed

SECTION VII — ADDITIONAL INFORMATION — INITIAL AND RENEWAL REQUESTS

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

ATTACHMENT 7
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS COMPLETION INSTRUCTIONS

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

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

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

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 to make a determination about the request.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents to request PA for GLP-1 agents. Pharmacy providers are required to use the PA/PDL for GLP-1 Agents form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

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

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

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

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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION FOR ALL REQUESTS

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

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

Element 15
Indicate whether or not the member is currently receiving Lantus insulin injections.

Element 16
Indicate whether or not the member is currently receiving insulin injections other than Lantus insulin.

Element 17
Indicate whether or not the member currently has or is there a history of pancreatitis.

Element 18
Indicate whether or not the member currently has or is there a history of gastroparesis.

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

Element 20
Indicate the member's most current hemoglobin (HbA1c). In the STAT-PA system, indicate the member's most current HbA1c as a three-digit number (e.g., if the member's most current HbA1c is 5.6 percent, enter "056").

Element 21
Indicate the date the member's most current HbA1c was measured in MM/DD/CCYY format. The member's most current HbA1c measurement must be within the past six months.

Element 22
Indicate whether or not the member has been taking the maximum dose of metformin (1,700 mg/day to 2,500 mg/day) for the past three months.

Element 23
Indicate whether or not the member is currently taking and will continue to take the maximum effective dose of metformin.

Element 24
Indicate whether or not the member is unable to take the maximum effective dose of metformin. If yes, indicate the reason(s) why the member is not taking the maximum effective dose of metformin in the space provided.

Element 25
Indicate whether or not the member has been taking the maximum effective dose of a sulfonylurea for the past three months.

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

Element 27
Indicate whether or not the member is unable to take the maximum effective dose of a sulfonylurea. If yes, indicate the reason(s) why the member is not taking the maximum effective dose of a sulfonylurea in the space provided.

Element 28
Indicate whether or not the member is currently using a GLP-1 agent. If yes, complete Section IIIA of the PA/PDL for GLP-1 Agent form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING A GLP-1 AGENT

Element 29
Indicate whether or not the member has been using a GLP-1 agent for the past six months.

Element 30
Indicate whether or not the member's most current HbA1c has decreased by at least 0.5 percent since starting a GLP-1 agent.

Element 31
Indicate whether or not the member's HbA1c has dropped below seven percent since starting a GLP-1 agent.

SECTION IIIB — CLINICAL INFORMATION FOR VICTOZA REQUESTS ONLY
Prior authorization requests for Victoza must be submitted on paper by fax or mail.

Element 32
Indicate whether or not the member has tried and failed on the maximum dose of Byetta. If yes, indicate the dose, directions for use, and the approximate dates Byetta was used in the space provided. In addition, describe in detail how the member failed to achieve an adequate therapeutic response or why the member is unable to continue treatment with Byetta.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 33 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 34 — Days' Supply Requested
Enter the requested days' supply.

Element 35 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider taxonomy code is not 333600000X.

Element 36 — Date of Service
Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 37 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 38 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 39 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 40 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 41 — Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — AUTHORIZED SIGNATURE

Element 42 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 43 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 44
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 8
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00238 (03/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions, F-00238A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/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 Glucagon-Like Peptide (GLP-1) Agents form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR ALL REQUESTS

13. Diagnosis Code and Description

14. Is the member 18 years of age or older?	❑ Yes	❑ No
15. Is the member currently receiving Lantus insulin injections?	❑ Yes	❑ No
16. Is the member currently receiving insulin injections other than Lantus insulin?	❑ Yes	❑ No
17. Does the member currently have or is there a history of pancreatitis?	❑ Yes	❑ No
18. Does the member currently have or is there a history of gastroparesis?	❑ Yes	❑ No
19. Is the member participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR ALL REQUESTS (Continued)

20. Indicate the member's most current hemoglobin (HbA1c).	21. Date Member's HbA1c Measured (Within the Past Six Months)
_____ _____. _____ %	_____ _____ /_____ _____ / _____ _____ _____ _____ Month Date Year

22. Has the member been taking the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day) for the past three months? ❑ Yes ❑ No

23. Is the member currently taking and will continue to take the maximum effective dose of metformin? ❑ Yes ❑ No

24. Is the member unable to take the maximum effective dose of metformin? ❑ Yes ❑ No

If yes, indicate the reason(s) why the member is not taking the maximum effective dose of metformin in the space provided.

25. Has the member been taking the maximum effective dose of a sulfonylurea for the past three months? ❑ Yes ❑ No

26. Is the member currently taking and will continue to take the maximum effective dose of a sulfonylurea? ❑ Yes ❑ No

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

27. Is the member unable to take the maximum effective dose of a sulfonylurea? ❑ Yes ❑ No

If yes, indicate the reason(s) why the member is not taking the maximum effective dose of a sulfonylurea in the space provided.

28. Is the member currently using a GLP-1 agent? ❑ Yes ❑ No

If yes, complete Section IIIA of this form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING A GLP-1 AGENT

29. Has the member been using a GLP-1 agent for the past six months? ❑ Yes ❑ No

30. Since starting a GLP-1 agent, has the member's most current HbA1c decreased by at least 0.5 percent? ❑ Yes ❑ No

31. Since starting a GLP-1 agent, has the member's HbA1c dropped below seven percent? ❑ Yes ❑ No

SECTION IIIB — CLINICAL INFORMATION FOR VICTOZA REQUESTS ONLY (Complete this section only for PA requests for Victoza. Prior authorization requests for Victoza must be submitted on paper.)

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

If yes, indicate the dose, directions for use, and the approximate dates Byetta was used in the space provided. In addition, describe in detail how the member failed to achieve an adequate therapeutic response or why the member is unable to continue treatment with Byetta.

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

33. National Drug Code (11 Digits)	34. Days' Supply Requested (Up to 365 Days)

35. NPI

36. 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.)

37. Place of Service

38. Assigned PA Number

39. Grant Date	40. Expiration Date	41. Number of Days Approved

SECTION V — AUTHORIZED SIGNATURE

42. **SIGNATURE** — Prescriber	43. Date Signed

SECTION VI — ADDITIONAL INFORMATION

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