ForwardHealth
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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Blood Banks, Dentists, 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 2012 Preferred Drug List Review and Other Pharmacy Policy Changes

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List and other pharmacy policy changes effective for dates of service on and after July 1, 2012.

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List (PDL) and other pharmacy policy changes effective for dates of service (DOS) on and after July 1, 2012, unless otherwise noted.

For information about covered drugs, providers may refer to the following benefit plan-specific resources 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.

This *Update* provides an overview of the major changes to certain PDL drug classes but does not address all of the changes made in PDL 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. The clinical criteria for prior authorization (PA) approval of a non-preferred drug are the following, unless drug class-specific clinical criteria have been established and published by ForwardHealth:

- A clinically significant drug interaction between another medication the member is taking and the preferred drug(s).
- A clinically significant adverse drug reaction while taking a preferred drug(s).
- An unsatisfactory therapeutic response with a preferred drug(s) in the same drug class as the non-preferred drug.
- A medical condition(s) that prevents the use of a preferred drug(s).

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete the appropriate PA form for the drug. Prescribers are required to send the PA form 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. The PA form 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 PA form to submit a PA request to ForwardHealth. Prescribers should not submit the PA form to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation.

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 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.

Pharmacy providers are required to submit the PA request using the PA form received from the prescriber and using the PA request 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 and any supporting documentation received from the prescriber.

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 Class

The H. Pylori drug class will be added to the PDL on July 1, 2012. In addition, H. Pylori drugs will no longer be diagnosis restricted. A diagnosis code is no longer required on claims for H. Pylori drugs.

Providers may refer to the Preferred Drug List Quick Reference on the Portal for the preferred and non-preferred drugs in the H. Pylori drug class.

Obsolete Drug Class

The colony stimulating factors drug class will be removed from the PDL effective for DOS on and after July 1, 2012. Colony stimulating factors continue to be covered for Standard Plan, Medicaid, and SeniorCare members, and will no longer be preferred or non-preferred. Neupogen continues to be a covered drug for Core Plan members.

Colony stimulating factors continue to be noncovered drugs for Basic Plan members.

Provider-administered drugs continue to be available for Benchmark Plan members.

Drug Class Name Changes

As a result of the summer 2012 PDL review, the following drug classes will be renamed:

- Macrolides/ketolides will be renamed antibiotics, macrolides/ketolides.
- Tetracyclines will be renamed antibiotics, tetracyclines.
- Topical, anti-infectives will be renamed antibiotics, topical.

Providers may refer to the Preferred Drug List Quick Reference for a list of preferred and non-preferred drugs in each drug class and the benefit plan-specific product lists on the Portal for a list of covered drugs in each drug class.

Acne Agents, Topical

Clindamycin foam will be a non-preferred drug in the acne agents, topical drug class.

In the acne agents, topical drug class on the Preferred Drug List Quick Reference, ForwardHealth will list only the preferred federal legend generic and brand name drugs. Federal legend non-preferred drugs in the acne agents, topical drug class will not be listed.

Drugs not listed in the acne agents, topical drug class on the Preferred Drug List Quick Reference are one of the following:

- Considered to be non-preferred drugs and require PA for Standard Plan, Medicaid, and SeniorCare members.
- Noncovered by the Standard Plan, Medicaid, and SeniorCare (e.g., over-the-counter [OTC] drugs, drugs without signed manufacturer rebate agreements, convenience or combination packaged drugs, drugs terminated by the Centers for Medicare and Medicaid Services).

Providers may use the claim response or the Drug Search Tool on the Pharmacy page of the Providers area of the Portal to determine the most current covered drugs.

For Benchmark Plan, Core Plan, and Basic Plan members, providers may refer to the benefit plan-specific product lists on the Portal for the most current list of covered acne agents, topical.

As a reminder, convenience and combination packaged drugs are not covered by ForwardHealth. For more information about the convenience and combination packaging policy, refer to Convenience and Combination Packaging under the Reminders section later in this *Update*.

Analgesics, Opioids Long-Acting

Kadian will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Kadian continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Beginning July 1, 2012, the following will be preferred drugs in the analgesics, opioids long-acting drug class for Standard Plan, Medicaid, and SeniorCare members:

- Butrans transdermal.
- Fentanyl transdermal.
- Methadone.
- Morphine ER tablets.

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

Fentanyl transdermal, methadone, and morphine ER tablets continue to be covered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Angiotensin Modulators, Combination

Brand name Lotrel will be a preferred drug (in addition to other preferred drugs) in the angiotensin modulators, combination drug class for Standard Plan, Medicaid, and SeniorCare members. Lotrel will no longer require brand medically necessary PA. Generic amlodipine/benazepril continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members.

ForwardHealth will automatically apply the generic copayment and a generic dispensing fee on claims for Lotrel.

Amlodipine/benazepril continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Antibiotics, GI

Metronidazole

Metronidazole capsule will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Metronidazole capsule continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Metronidazole tablet continues to be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Metronidazole tablet continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Tindamax and Tinidazole

Tindamax and tinidazole will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Prior authorization is not required for Tindamax and tinidazole for Standard Plan and Medicaid members who are 18 years of age or younger. For Standard Plan, Medicaid, and SeniorCare members 19 years of age or older, PA is required for Tindamax and tinidazole.

Tindamax will be a noncovered drug for Core Plan members. Tindamax continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Tinidzole will be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Anticoagulants

The antithrombitic agents, LMWHs and Xa inhibitors drug class and the antithrombotic agents, oral drug class will be combined into a single drug class, the anticoagulants drug class. The anticoagulants drug class will be a covered drug class for Core Plan members.

Arixtra

Arixtra will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Arixtra will be a noncovered drug for Core Plan members. Arixtra continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Fragmin Syringes and Fragmin Vial

Fragmin syringes continue to be a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Fragmin syringes continue to be a noncovered drug for Benchmark Plan and Basic Plan members.

Fragmin vial will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Fragmin vial will be a noncovered drug for Core Plan members. Fragmin vial continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Pradaxa

Pradaxa continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. An allowable diagnosis code must be indicated on claims and PA requests for Pradaxa. Pradaxa is a noncovered drug for uses outside the allowable diagnosis code. Providers may refer to the Diagnosis Restricted Drugs data table on the Portal for the most current list of allowable diagnosis codes.

Quantity limits continue to apply to Pradaxa. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Portal for the most current quantity limits. Providers may refer to the Online Handbook for more information about exceptions to the quantity limit policy.

Pradaxa is a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Xarelto 10 mg

Xarelto 10 mg will be a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Xarelto 10 mg will have quantity limits. Members will be limited to 35 tablets per rolling year. If a member is prescribed 35 tablets

of Xarelto 10 mg for 35 days of treatment, providers may dispense 35 tablets and ForwardHealth will accept and reimburse claims for a quantity of 35 with a 35-day supply. If it is medically appropriate for a member to exceed the quantity limit, pharmacy providers may request a quantity limit policy override. For more information about quantity limit policy overrides, providers may refer to the Quantity Limits topic (topic #3444) in the Submission section of the Claims chapter of the Pharmacy service area of the Online Handbook.

Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Portal for the most current quantity limits. Providers may refer to the Online Handbook for information about exceptions to the quantity limit policy.

A diagnosis restriction does not apply to Xarelto 10 mg.

Xarelto 10 mg continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Xarelto 15 mg and 20 mg

Xarelto 15 mg and 20 mg will be preferred drugs for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Members will be limited to 34 tablets per 34-day supply. If it is medically appropriate for a member to exceed the quantity limit, pharmacy providers may request a quantity limit policy override. For more information about quantity limit policy overrides, providers may refer to the Quantity Limits topic (topic #3444) in the Submission section of the Claims chapter of the Pharmacy service area of the Online Handbook.

An allowable diagnosis code must be indicated on claims and PA requests for Xarelto 15 mg and 20 mg. Xarelto 15 mg and 20 mg are noncovered drugs for uses outside the allowable diagnosis code. Providers may refer to the Diagnosis Restricted Drugs data table on the Portal for the most current list of allowable diagnosis codes.

Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Portal for the most current quantity limits. Providers may refer to the Online Handbook for information about exceptions to the quantity limit policy.

Xarelto 15 mg and 20 mg continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

Antifungals, Topical

There are no changes to preferred and non-preferred drugs in the antifungals, topical drug class.

As a reminder, antifungal topical sprays and kits are not covered by ForwardHealth because they are considered to be convenience or combination packaged products. For more information about the convenience and combination packaging policy, refer to the Convenience and Combination Packaging under the Reminders section later in this *Update*.

Antiparasitics, Topical

Brand name Ovide will be a preferred drug (in addition to other preferred drugs) for Standard Plan, Medicaid, and SeniorCare members. Ovide will no longer require brand medically necessary PA.

ForwardHealth will automatically apply the generic copayment and a generic dispensing fee on claims for Ovide.

Generic malathion continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members.

Generic malathion will be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Beta Blockers

Several generic beta blocker drugs will change from preferred drugs to non-preferred drugs on the PDL for Standard Plan, Medicaid, and SeniorCare members. Pharmacy providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred

drug in the beta blockers drug class or request PA for a non-preferred drug.

For Benchmark Plan, Core Plan, and Basic Plan members, providers should refer to the benefit plan-specific product lists on the Portal for the most current list of covered beta blocker drugs.

Calcium Channel Blocking Agents

Generic verapamil 360 mg capsules will change from a preferred drug to a non-preferred drug (in addition to other non-preferred drugs) for Standard Plan, Medicaid, and SeniorCare members. For DOS on and after July 1, 2012, PA will be required for verapamil 360 mg capsules.

Verapamil 360 mg capsules continue to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Providers may refer to the Preferred Drug List Quick Reference for a list of preferred verapamil products.

Erythropoiesis Stimulating Proteins

Erythropoiesis stimulating protein drugs will no longer be diagnosis-restricted drugs; therefore, diagnosis codes are no longer required on claims for erythropoiesis stimulating proteins. As a result, ForwardHealth has revised the Diagnosis Restricted Drugs data table on the Portal. Providers may refer to the Diagnosis Restricted Drugs data table for the most current list of diagnosis-restricted drugs and allowable diagnosis codes.

Growth Hormone Drugs

All growth hormone drugs continue to require clinical PA for Standard Plan, Medicaid, and SeniorCare members.

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

Saizen

Saizen will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members.

Genotropin

Genotropin will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Pharmacy providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug (i.e., Norditropin, Nutropin, Nutropin AQ, Nutropin AQ Nuspin, Saizen) in the growth hormone drugs drug class or request PA for a non-preferred drug.

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

Prior authorization requests for Genotropin for Standard Plan, Medicaid, and SeniorCare members must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092 (10/11). Prior authorization requests for Genotropin may be submitted on the Portal or on paper by fax or mail. Prior authorization requests for Genotropin can no longer be submitted using the STAT-PA system.

Hepatitis C Agents

ForwardHealth has split the hepatitis C agents drug class into the following separate classes:

- Hepatitis C, alfa interferon.
- Hepatitis C, nucleoside analogues.
- Hepatitis C, protease inhibitors.

When monitoring preferred and non-preferred drugs, ForwardHealth monitors each hepatitis C drug class as a separate class on the PDL.

Providers may refer to the Preferred Drug List Quick Reference for a list of preferred and non-preferred drugs in each drug class for Standard Plan, Medicaid, and SeniorCare members. For Benchmark Plan, Core Plan, and Basic Plan members, providers may refer to the benefit plan-specific product lists on the Portal for a list of covered drugs. Providers may refer to the BadgerCare Plus Core Plan Brand Name Quick Reference on the Portal for the most current list of covered brand name drugs for Core Plan members.

Hypoglycemics, GLP-1 Agents

Byetta will be a preferred drug that requires clinical PA for Standard Plan, Medicaid, and SeniorCare members. Bydureon and Victoza continue to be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members.

Prior authorization requests for glucagon-like peptide (GLP-1) agents must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents, F-00238 (06/12). ForwardHealth has revised the PA/PDL for GLP-1 Agents. Providers may refer to Attachments 1 and 2 of this *Update* for a revised copy of the completion instructions and form.

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

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 hemoglobin (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.

An allowable diagnosis code must be indicated on claims and PA requests for GLP-1 agents. Glucagon-like peptide agents are noncovered drugs for uses outside the allowable diagnosis codes. Providers may refer to the Diagnosis Restricted Drugs data table on the Portal for the most current list of diagnosis-restricted drugs and allowable diagnosis codes.

Bydureon, Byetta, and Victoza are noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Clinical Criteria for Byetta

Clinical criteria for approval of a PA request for Byetta 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 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.

Clinical Criteria for Bydureon

Clinical criteria for approval of a PA request for Bydureon 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.
- 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 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.
- 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.

For PA requests for Bydureon, members must have taken the maximum dose of Byetta for at least three consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

Prior authorization requests for Bydureon will not be approved if the member is using any insulin, including basal insulin. Only members who are not taking insulin may qualify for Bydureon.

Clinical Criteria for Victoza

Clinical criteria for approval of a PA request for Victoza 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 basal 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 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 basal 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 basal 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.

For PA requests for Victoza, members must have taken the maximum dose of Byetta for at least three consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

Prior authorization requests for Victoza will not be approved if the member is using bolus insulin (i.e., meal-time insulin).

Hypoglycemics, Thiazolidinediones

Actoplus Met

Actoplus Met will be a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Actoplus Met continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Avandia, Avandamet, and Avandaryl

Avandia, Avandamet, and Avandaryl continue to be non-preferred drugs that require PA for Standard Plan, Medicaid, and SeniorCare members. Prior authorization requests for Avandia, Avandamet, and Avandaryl should be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/11). Prior authorization requests for Avandia, Avandamet, and Avandaryl should no longer be submitted on the Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08). This change is being made to align with Food and Drug Administration Risk Evaluation and Mitigation Strategies. Providers may refer to the Forms page on the Portal for copies of the forms and completion instructions.

Avandia, Avandamet, and Avandaryl continue to be covered for members taking the drugs as of September 27, 2010, who were grandfathered at that time.

Avandia, Avandamet, and Avandaryl continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members and SeniorCare members in levels 2b and 3.

Duetact

Duetact will be a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Duetact continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Lipotropics, Fibric Acids

Fenofibric Acid

Fenofibric acid will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Fenofibric acid will be a

covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Fenofibrate Tablets and Capsules

Fenofibrate tablets will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Fenofibrate tablets continue to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Fenofibrate capsules continue to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Fenofibrate capsules will be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Lipotropics, Statins

Crestor will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Prior authorization will be required for Crestor for DOS on and after July 1, 2012. Pharmacy providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug (i.e., atorvastatin, Lescol, Lescol XL, lovastatin, pravastatin, or simvastatin) in the lipotropics, statins drug class or request PA for a non-preferred drug.

ForwardHealth will begin accepting PA requests for Crestor for Standard Plan, Medicaid, and SeniorCare members on and after July 1, 2012.

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

Migraine Agents, Injectable

Brand name Imitrex injectable will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Imitrex injectable will no longer require brand medically necessary PA.

ForwardHealth will automatically apply the generic copayment and a generic dispensing fee on claims for Imitrex injectable.

Generic sumatriptan injectable will change from a preferred drug to a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. For DOS on and after August 1, 2012, PA will be required for generic sumatriptan injectable. To allow time for pharmacy providers to switch a member's prescription from generic sumatriptan injectable to Imitrex injectable, a transition period for DOS from July 1, 2012, through July 31, 2012, will be allowed and claims for generic sumatriptan injectable and Imitrex injectable will be covered without PA.

Generic sumatriptan injectable continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Sumavel continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Sumavel continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members and SeniorCare members in levels 2b and 3.

Prior Authorization Requests for Migraine Agents, Injectable

ForwardHealth has created a new form, the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable, F-00622 (06/12), and established clinical criteria. Prior authorization requests for injectable migraine agents may be submitted on the PA/PDL for Migraine Agents, Injectable effective for DOS on and after July 1, 2012. Prior authorization requests for injectable migraine agents may be submitted on paper by fax or mail. Providers may refer to Attachments 3 and 4 for a copy of the completion instructions and form.

Prior authorization requests for Sumavel submitted before July 1, 2012, should be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, F-00280 (dated 10/11). On and after July 1, 2012, PA requests for Sumavel must be submitted on the PA/PDL for Migraine Agents, Injectable form. The PA/PDL for Migraine Agents form will no longer be accepted.

Clinical Criteria

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

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to an oral sumatriptan product, or
- The member has a medical condition(s) that prevents him or her from using an oral sumatriptan product, and
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to a nasal sumatriptan product, or
- The member has a medical condition(s) that prevents him or her from using a nasal sumatriptan product, and
- The member has used a preferred injectable sumatriptan product and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction, or
- The member has a medical condition(s) that prevents him or her from using a preferred injectable sumatriptan product, and
- Member preference is not the reason why the member is unable to use a preferred injectable sumatriptan product.

Migraine Agents, Other

Naratriptan oral, sumatriptan oral, and Relpax continue to be preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Naratriptan oral and sumatriptan oral continue to be covered drugs for Benchmark Plan, Core Plan, and Basic Plan members. Relpax continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Brand name Imitrex nasal spray will be a preferred drug (in addition to other preferred drugs) for Standard Plan, Medicaid, and SeniorCare members. Imitrex nasal spray will no longer require brand medically necessary PA.

ForwardHealth will automatically apply the generic copayment and a generic dispensing fee on claims for Imitrex nasal spray.

Generic sumatriptan nasal spray will change from a preferred drug to a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. For DOS on and after August 1, 2012, PA will be required for generic sumatriptan nasal spray. To allow time for pharmacy providers to switch a member's prescription from generic sumatriptan nasal spray to Imitrex nasal spray, a transition period for DOS from July 1, 2012, through July 31, 2012, will be allowed and claims for generic sumatriptan nasal spray and Imitrex nasal spray will be covered without PA.

Generic sumatriptan nasal spray continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Note: Amerge and Imitrex tablets continue to require brand medically necessary PA.

Prior Authorization Requests for Migraine Agents, Other

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents form and renamed it the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other, F-00280 (06/12). Providers may refer to Attachments 5 and 6 for a copy of the completion instructions and form.

Clinical Criteria for Non-preferred Migraine Agents, Other

Clinical criteria for approval of a PA request for non-preferred oral migraine agents are all of the following:

- The member has previously taken any formulation of a sumatriptan product (i.e., injection, nasal, tablet) and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has previously taken a naratriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has previously taken an eletriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Clinical Criteria for Cambia

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

- The member has previously taken any formulation of a sumatriptan product (i.e., injection, nasal, tablet) and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction, and
- The member has previously taken a naratriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction, and
- The member has previously taken an eletriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction, or
- There is a clinically significant drug interaction between another medication the member is taking and a serotonin 5-HT1 receptor agonist agent (i.e., triptan), and
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs, and
- The member has not experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to diclofenac.

Opioid Dependency Agents

Suboxone film and buprenorphine tablets continue to be preferred drugs that require clinical PA for Standard Plan, Core Plan, Medicaid, and SeniorCare members.

Suboxone tablets will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members.

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

Suboxone tablets continue to be noncovered drugs for Core Plan members.

Pulmonary Arterial Hypertension

Ventavis will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Ventavis will be a noncovered drug for Core Plan members. Ventavis continues to be a noncovered drug for Benchmark Plan and Basic Plan members.

Topical, Anti-Infectives

With the exception of Altabax, topical anti-infective drugs will no longer be diagnosis-restricted drugs; therefore, diagnosis codes are no longer required on claims for topical anti-infective drugs (except for Altabax). As a result, ForwardHealth has revised the Diagnosis Restricted Drugs data table on the Portal. Providers may refer to the Diagnosis Restricted Drugs data table for the most current list of diagnosis-restricted drugs and allowable diagnosis codes.

Pharmacy Policy Changes

Kalydeco

Kalydeco (ivacaftor) is not included in a drug class on the PDL, but it is a drug that requires PA and is only indicated for the treatment of a rare form of cystic fibrosis with a G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene. Providers should submit PA requests for Kalydeco on paper using the PA/DGA and the Prior Authorization Request Form (PA/RF), F-11018 (10/08). Clinical documentation supporting the use of Kalydeco must be submitted with each PA request.

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

- The member has a diagnosis of cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed the member has a G551D mutation in the CFTR gene. (*Note:* A copy of the test results should be included with an initial PA request.)
- The prescriber has confirmed the member does not have a homozygous F508del mutation in the CFTR gene.

- The prescriber has confirmed liver function testing is being periodically monitored. (*Note:* A copy of the test results completed within the last 90 days should be included with initial and renewal PA requests.)

Prior authorization requests for Kalydeco may be approved for a maximum approval period of 365 days.
Kalydeco is a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Physician-Administered Drugs Diagnosis Restrictions

Diagnosis restrictions have been removed from colony stimulating factors and erythropoiesis stimulating proteins. As a result, the Diagnosis Code-Restricted Physician-Administered Drugs table on the Physician page of the Providers area of the Portal has been revised. Providers may refer to the table for the most current list of diagnosis-restricted drugs and allowable diagnosis codes for provider-administered drugs.

As a reminder, providers are required to comply with the requirements of the federal Deficit Reduction Act of 2005 and submit National Drug Codes with Healthcare Common Procedure Coding System procedure codes on claims for provider-administered drugs. Providers may refer to the Provider-Administered Drugs topics (topics #4382 and #5697) in the Online Handbook on the Portal for more detailed information about claim submissions, coverage rules, and information about obtaining provider-administered drugs.

Third-Party Web Site Information

The ForwardHealth Portal allows providers access to all policy and billing information for BadgerCare Plus, Medicaid, SeniorCare, and Wisconsin Chronic Disease Program in one centralized place. Prior authorization request forms and information about ForwardHealth's policies should be obtained from the ForwardHealth Portal at *www.forwardhealth.wi.gov*/or Provider Services at (800) 947-9627. Third-party Web sites are not affiliated with or endorsed by ForwardHealth.

Reminders

The following information is a reminder for providers of current policy. The following policies remain unchanged.

Claims for Non-preferred Drugs

Pharmacy providers who submit real-time pharmacy claims for non-preferred drugs will receive an Explanation of Benefits (EOB) code and a National Council for Prescription Drug Programs (NCPDP) reject code indicating a denial in the claim response. In addition, as a result of the implementation of the NCPDP version D.0, a list of preferred drugs is included in the claim response.

For non-real-time pharmacy claims, providers will receive EOB codes on their Remittance Advice and reason and remark codes on the 835 Health Care Claim Payment/Advice.

Copayment and Dispensing Fee for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copayment and dispensing fee to a brand name drug when a drug that previously required brand medically necessary PA moves to a preferred drug on the PDL and the available generic equivalent(s) are non-preferred drugs.

Note: This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and net yet cost-effective when compared with brand pricing (i.e., a Maximum Allowed Cost rate has not been established).

For drugs determined to be included in this policy, ForwardHealth will automatically apply the generic copayment when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate an NCPDP Dispense As Written code on claims to ensure the generic copayment deduction. In addition, ForwardHealth will automatically apply a generic dispensing fee to claims for which a specific brand name drug is preferred over the generic equivalent.

The following table includes the most current list of drugs for which this policy applies. Drugs listed in bold font are drugs that have been added to the list. This list is available on the Preferred Drug List Quick Reference on the Portal. Providers are encouraged to review the list closely to identify future changes.

Drug Class	Drug Name	Effective Date
Acne Agents	Differin cream	January 1, 2012
	Differin 0.1% gel	January 1, 2012
Alzheimer's Agents	Exelon capsules	January 1, 2012
Anticonvulsants	Depakote Sprinkle	January 1, 2012
	Tegretol XR 200 mg	January 1, 2012
	Tegretol XR 400 mg	January 1, 2012
Antidepressants, Other	Effexor XR	January 1, 2012
	Wellbutrin XL	January 1, 2012
Antiemetics, Cannabinoids	Marinol	January 1, 2012
Angiotensin Modulators, Combination	**Lotrel**	**July 1, 2012**
Antiparasitics, Topical	**Ovide**	**July 1, 2012**
Antithrombotic Agents, LMWHs and Xa Inhibitors	Lovenox	January 1, 2012
Beta Blockers	Toprol XL	July 1, 2011
Bone Resorption Suppression	Miacalcin nasal spray	October 1, 2009
Intranasal Rhinitis Agents	Astelin	January 1, 2012
Migraine Agents, Injectable	**Imitrex injectable**	**July 1, 2012**
Migraine Agents, Other	**Imitrex nasal spray**	**July 1, 2012**
Ophthalmics Antibiotic/Steroid Combinations	Tobradex suspension	January 1, 2012
Ophthalmics, Glaucoma — Other	Alphagan P 0.15%	January 1, 2012
Stimulants and Related Agents	Adderall XR	January 1, 2012

Convenience and Combination Packaging

ForwardHealth does not reimburse for convenience or combination packaging. Drugs that are sold in small package sizes (e.g., single-use packages) are considered to be convenience packaging. Drugs that are sold in a package that includes a prescription drug along with a noncovered item, such as an OTC drug (fish oil), a personal care item (skin moisturizer), and a common medicine chest item (Band-Aids™) are combination packaging. In some cases, the drug may be separately reimbursable. For example, an acne agent packaged with an OTC face wash is not covered, but the acne agent may be covered by itself.

Expedited Emergency Supply Drugs

As a result of changes made during the summer 2012 PDL review, changes have been made to the Expedited Emergency Supply Request Drugs data table on the Portal. The Emergency Medication Dispensing topic (topic #1399) 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 dispensing an emergency supply of medication.

Fertility and Impotence Drugs

According to DHS 107.10(2)(f) and 107.10(2)(g), Wis. Admin. Code, the following drugs require PA:

- Drugs identified by the Department of Health Services (DHS) that are sometimes used to enhance the prospect

of fertility in males or females, when proposed to be used for treatment of a condition not related to fertility.
- Drugs identified by the DHS that are sometimes used to treat impotence, when proposed to be used for the treatment of a condition not related to impotence.

These types of drugs are not covered unless a paper PA request is submitted on the PA/DGA and the drug is being used to treat a condition unrelated to fertility or impotence.

Opioid Drugs

As a reminder, ForwardHealth continues to monitor such policies as prescription fill limits, quantity limits, and early refill limits for opioid drugs. Providers may refer to the Online Handbook on the Portal for more information about these policies.

Providers may refer to the Opioid Monthly Prescription Fill Limit topic (topic #11097) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook for more information about monthly prescription limits for opioids.

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 PA form received from the prescriber.

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 form and supporting documentation received from the prescriber.

For More Information

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

Information Regarding Managed Care Organizations

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

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

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

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

P-1250

This *Update* was issued on 6/19/2012 and information contained in this *Update* was incorporated into the Online Handbook on 7/9/2012.

ATTACHMENT 1
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.)

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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, F-00238, 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
    313 Blettner Blvd
    Madison WI 53784

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
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the member is currently receiving Lantus insulin injections.

Element 16
Check the appropriate box to indicate whether or not the member is currently receiving insulin injections other than Lantus insulin.

Element 17
Check the appropriate box to indicate whether or not the member currently has or is there a history of pancreatitis.

Element 18
Check the appropriate box to indicate whether or not the member currently has or is there a history of gastroparesis.

Element 19
Check the appropriate box to 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
Check the appropriate box to 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
Check the appropriate box to indicate whether or not the member is currently taking and will continue to take the maximum effective dose of metformin.

Element 24
Check the appropriate box to 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
Check the appropriate box to indicate whether or not the member has been taking the maximum effective dose of a sulfonylurea for the past three months.

Element 26
Check the appropriate box to 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
Check the appropriate box to 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
Check the appropriate box to 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
Check the appropriate box to indicate whether or not the member has been using a GLP-1 agent for the past six months.

Element 30
Check the appropriate box to 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
Check the appropriate box to indicate whether or not the member's HbA1c has dropped below seven percent since starting a GLP-1 agent.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED GLP-1 AGENTS ONLY
Prior authorization requests for Victoza must be submitted on paper by fax or mail.

Element 32
Check the appropriate box to indicate whether or not the member has taken the maximum dose of Byetta for at least three consecutive months in the last year and failed to achieve at least a 0.5 percent decrease in HbA1c. If yes is checked, indicate the dates Byetta was taken, the dose of Byetta, and directions for use. In addition, list the member's HbA1c values prior to starting Byetta, the member's HbA1C values during treatment with Byetta, and the dates the values were measured in the space provided.

Element 33
Check the appropriate box to indicate whether or not the member has taken Byetta in the last year and experienced a clinically significant adverse drug reaction. If yes is checked, indicate the dates Byetta was taken, the dose of Byetta, directions for use, and specific details about the clinically significant adverse drug reaction in the space provided.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 34 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 35 — Days' Supply Requested
Enter the requested days' supply.

Element 36 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider taxonomy code is not 333600000X.

Element 37 — 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 38 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 39 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 40 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 41 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 42 — 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 43 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 44 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 45
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 2
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 (06/12)

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 — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED GLP-1 AGENTS ONLY (Complete this section only for PA requests for non-preferred GLP-1 agents. Prior authorization requests for non-preferred GLP-1 agents must be submitted on paper.)

32. In the last year, has the member taken the maximum dose of Byetta for at least three consecutive months and failed to achieve at least a 0.5 percent decrease in HbA1c? ❑ Yes ❑ No

If yes, indicate the dates Byetta was taken, the dose of Byetta, and directions for use. In addition, list the member's HbA1c values prior to starting Byetta, the member's HbA1c values during treatment with Byetta, and the dates the values were measured in the space provided.

Continued

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED GLP-1 AGENTS ONLY (Continued)

33. Has the member taken Byetta in the last year and experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the dates Byetta was taken, the dose of Byetta, directions for use, and specific details about the clinically significant adverse drug reaction in the space provided.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

34. National Drug Code (11 Digits)	35. Days' Supply Requested (Up to 365 Days)

36. NPI

37. 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.)

38. Place of Service

39. Assigned PA Number

40. Grant Date	41. Expiration Date	42. Number of Days Approved

SECTION V — AUTHORIZED SIGNATURE

43. **SIGNATURE** — Prescriber	44. Date Signed

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MIGRAINE AGENTS, INJECTABLE 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, Injectable, F-00622. Pharmacy providers are required to use the PA/PDL for Migraine Agents, Injectable 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
    313 Blettner Blvd
    Madison WI 53784

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 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 Migraine Agents, Injectable 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 appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to an oral sumatriptan product. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the oral sumatriptan product was taken in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents him or her from using an oral sumatriptan product. If yes is checked, list the medical condition(s) in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to a nasal sumatriptan product. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the nasal sumatriptan product was used in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents him or her from using a nasal sumatriptan product. If yes is checked, list the medical condition(s) in the space provided.

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

Element 19
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents him or her from using a preferred injectable sumatriptan product. If yes is checked, indicate the medical condition(s) in the space provided.

Element 20
Check the appropriate box to indicate whether or not member preference is the reason why the member is unable to use a preferred injectable sumatriptan product.

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.

Code	Description
01	Pharmacy
13	Assisted living facility
14	Group home
32	Nursing facility
34	Hospice
50	Federally qualified health center
65	End-stage renal disease treatment facility
72	Rural health clinic

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 4
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable Completion Instructions, F-00622A. 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, Injectable form signed by the prescriber before 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

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to an oral sumatriptan product? ❑ Yes ❑ No

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

15. Does the member have a medical condition(s) that prevents him or her from using an oral sumatriptan product? ❑ Yes ❑ No

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

Continued

SECTION III — CLINICAL INFORMATION (Continued)

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to a nasal sumatriptan product? ❑ Yes ❑ No

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

17. Does the member have a medical condition(s) that prevents him or her from using a nasal sumatriptan product? ❑ Yes ❑ No

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

18. Has the member used a preferred injectable sumatriptan product and experienced an unsatisfactory therapeutic response or 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 injectable sumatriptan product was used in the space provided.

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

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

20. Is member preference the reason why the member is unable to use a preferred injectable sumatriptan product? ❑ Yes ❑ No

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 5
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MIGRAINE AGENTS, OTHER 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, Other, F-00280. Pharmacy providers are required to use the PA/PDL for Migraine Agents, Other 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
    313 Blettner Blvd
    Madison WI 53784

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 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 Migraine Agents, Other 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 appropriate box to indicate whether or not the member has previously taken any formulation of a sumatriptan product (i.e., injection, nasal, tablets) and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes is checked, indicate the formulation(s) of the sumatriptan product taken, specific details about the unsatisfactory therapeutic response or clinically significant drug reaction, and the approximate dates the sumatriptan product(s) was taken in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member has previously taken a naratriptan product and experienced an unsatisfactory therapeutic response or experienced clinically significant adverse drug reaction. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the naratriptan product was taken in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has previously taken an eletriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the eletriptan product was taken in the space provided.

SECTION IIIA — ADDITIONAL INFORMATION FOR REQUESTS FOR CAMBIA ONLY

Element 17
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and a serotonin 5-HT1 receptor agonist agent (i.e., triptan). If yes is checked, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs (NSAIDs). If yes is checked, list the two preferred, generic NSAIDs and indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the two preferred, generic NSAIDs were taken in the spaces provided.

Element 19
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to diclofenac. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates diclofenac 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 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. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 25 — 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 26 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Code	Description
01	Pharmacy
13	Assisted living facility
14	Group home
32	Nursing facility
34	Hospice
50	Federally qualified health center
65	End-stage renal disease treatment facility
72	Rural health clinic

Element 27 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

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

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

Element 30 — 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 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 6
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other 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, Other 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 (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member previously taken any formulation of a sumatriptan product (i.e., injection, nasal, tablets) and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

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

Continued

SECTION III — CLINICAL INFORMATION (Continued)

15. Has the member previously taken a naratriptan product 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 naratriptan product was taken in the space provided.

16. Has the member previously taken an eletriptan product 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 eletriptan product was taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR REQUESTS FOR CAMBIA ONLY (Complete this section only for PA requests for Cambia.)

17. Is there a clinically significant drug interaction between another medication the member is taking and a serotonin 5-HT1 receptor agonist agent (i.e., triptan)? ❑ Yes ❑ No

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

18. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs (NSAIDs)? ❑ Yes ❑ No

    If yes, list the two preferred, generic NSAIDs and indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the two preferred, generic NSAIDs were taken in the spaces provided.

    A. _____

    B. _____

19. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to diclofenac? ❑ Yes ❑ No

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

Continued

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. Place of Service

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.