This *Update* has been revised since its original publication. On page 8, the name of the preferred drug in the Cytokine and CAM antagonist drug class used to treat ulcerative colitis has been changed to Humira®.

ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare

To: Blood Banks, Dentists, Federally Qualified Health Centers, Hospital Providers, 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

January 2013 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 January 1, 2013, unless otherwise noted.

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 January 1, 2013, 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. This *Update* does not contain any coverage or policy changes for the Wisconsin AIDS/HIV Drug Assistance Program (ADAP).

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 a 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 Classes

The antipsoriatics, topical drug class and the neuropathic pain drug class will be added to the PDL on January 1, 2013.

Providers may refer to the Preferred Drug List Quick Reference on the Portal for the preferred and non-preferred drugs in the antipsoriatics, topical drug class and the neuropathic pain drug class.

Neuropathic Pain

Cymbalta will be a preferred drug that no longer requires PA or step therapy for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Cymbalta will continue to be a noncovered drug for Benchmark Plan and Basic Plan members. The Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta forms will become obsolete and will be deleted from the Portal in January 2013.

Note: Gabapentin, Cymbalta, and Lyrica will all be preferred drugs in the neuropathic pain drug class. On the Preferred Drug List Quick Reference, Cymbalta is also listed as a preferred drug in the antidepressants, other and the fibromyalgia drug classes; Lyrica is also listed as a preferred drug in the anticonvulsants and fibromyalgia drug classes; and gabapentin is also listed as a preferred drug in the anticonvulsants drug class.

Gralise and Horizant will be non-preferred drugs in the neuropathic pain drug class for Standard Plan, Medicaid, and SeniorCare members and will continue to be diagnosis restricted. Providers may refer to the Diagnosis Restricted Drugs data table for the most current list of diagnosis-restricted drugs and allowable diagnosis codes. Gralise and Horizant are noncovered drugs for uses outside the allowable diagnosis codes.

Gralise and Horizant continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Alzheimer's Agents

Namenda is an N-Methyl-D-Aspartate Receptor Antagonist in the Alzheimer's agents drug class. Namenda is used in the treatment of Alzheimer's disease and dementia-related disorders.

Note: There are no adequate and well-controlled trials documenting the safety and efficacy of Namenda in any illness occurring in children.

Namenda will remain a preferred drug; however, effective for DOS on and after February 15, 2013, PA will be required for Namenda for members who are 44 years of age or younger. For members 45 years of age or older, PA will not be required for Namenda.

Namenda will be covered without PA for Standard Plan, Core Plan, and Medicaid members who are 44 years of age or younger *and* currently taking Namenda (as identified from claims history) until future policy review occurs.

Prior authorization requests for Namenda for members who are 44 years of age or younger, and who are not currently taking Namenda, should be submitted on paper using the Prior Authorization Drug Attachment (PA/DGA), F-11049 (07/12), and the Prior Authorization Request Form (PA/RF), F-11018 (07/12). Clinical documentation supporting an Alzheimer's disease or dementia indication for members who are 44 years of age or younger must be submitted with the PA request. Prior authorization forms are available on the Forms page of the Portal.

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

Anticoagulants

Effective for DOS on and after December 1, 2012, Xarelto is no longer diagnosis restricted. However, quantity limits continue to apply to Xarelto. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Providers area of the Portal for the most current quantity limits.

Antipsychotics

Olanzapine will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Olanzapine will be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Olanzapine ODT and Zyprexa ODT continue to be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Olanzapine ODT and Zyprexa ODT continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

COPD Agents

Daliresp will be added as a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. The allowable diagnosis for Daliresp is chronic obstructive pulmonary disease (COPD), and this diagnosis must be indicated on claims for Daliresp. Daliresp 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.

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

Spiriva will no longer be diagnosis restricted for Core Plan members.

Cough and Cold — Narcotic Liquids

In the cough and cold — narcotic liquids drug class on the Preferred Drug List Quick Reference, ForwardHealth will list only the preferred legend and over-the-counter (OTC) drugs by active ingredient name.

Drugs not listed in the cough and cold — narcotic liquids drug class on the Preferred Drug List Quick Reference are those that 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., certain OTC drugs, drugs without signed manufacturer rebate agreements, 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 cough and cold — narcotic liquids.

Cytokine and Cell Adhesion Molecule Antagonist Drugs

ForwardHealth has developed a new PA/PDL for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs form and revised clinical criteria on existing PA/PDL for Cytokine and CAM Antagonist Drugs forms. In addition, submission options for PA requests for Kineret® and Simponi™ have changed. Prior authorization requests for Kineret® and Simponi™ must be submitted on paper using the PA/PDL for Cytokine and CAM Antagonist Drugs form most appropriate to the diagnosis. Providers can no longer submit PA requests for Kineret® and Simponi using the STAT-PA system.

All PA requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper by fax or mail. Prior authorization requests for non-preferred cytokine and CAM antagonist drugs may *not* be submitted using the STAT-PA system.

Initial PA requests for non-preferred cytokine and CAM antagonist drugs will be approved for up to 183 days. Renewal PA requests for non-preferred cytokine and CAM antagonist drugs will be approved for up to one year.

Prior authorization requests for cytokine and CAM antagonist drugs will only be approved for use to treat the following identified clinical conditions:

- Ankylosing spondylitis.
- Crohn's disease.
- Plaque psoriasis.
- Psoriatic arthritis.
- Rheumatoid arthritis (RA) and polyarticular juvenile RA.
- Ulcerative colitis.

New Prior Authorization Form for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

ForwardHealth has created a new form, the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis, F-00694 (12/12), and established clinical criteria for coverage of cytokine and CAM antagonist drugs for ulcerative colitis. Prior authorization requests for cytokine and CAM antagonist drugs for ulcerative colitis may be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Ulcerative Colitis form for DOS on and after January 1, 2013. Providers may refer to

Attachments 1 and 2 of this *Update* for a copy of the completion instructions and form.

Revised Prior Authorization Forms for Cytokine and Cell Adhesion Molecule Antagonist Drugs

ForwardHealth has revised the following PA/PDL for Cytokine and CAM Antagonist Drugs forms:

- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304 (12/12).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305 (12/12).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306 (12/12).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307 (12/12).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA, F-11308 (12/12).

Providers may refer to Attachments 3 through 12 for the revised completion instructions and forms.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs

Clinical criteria for approval of a PA request for preferred cytokine and CAM antagonist drugs for Core Plan members are the same as the clinical criteria for Standard Plan, Medicaid, and SeniorCare members. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for Benchmark Plan or Basic Plan members.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis

Enbrel® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat ankylosing spondylitis.

Simponi™ is a non-preferred drug used to treat ankylosing spondylitis. For PA requests for Simponi™, the member must meet **all** clinical criteria below and have taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat ankylosing spondylitis are **all** of the following:

- The member has a diagnosis of ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- At least **one** of the following is true:
  - ✓ The member has moderate to severe axial symptoms of ankylosing spondylitis.
  - ✓ The member has received **one** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
    - Leflunomide.
    - Methotrexate.
    - A non-steroidal anti-inflammatory drug (NSAID) or cyclo-oxygenase (COX-2) inhibitor drug.
    - Oral corticosteroids.
    - Sulfasalazine.

Prior authorization requests for drugs for ankylosing spondylitis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

Cimzia® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat Crohn's disease.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat Crohn's disease are **all** of the following:

- The member has a diagnosis of Crohn's disease.
- The member has moderate to severe symptoms of Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ 5-aminosalicylic (5-ASA).
  - ✓ 6-mercaptopurine (6MP).
  - ✓ Azathioprine.
  - ✓ Methotrexate.
  - ✓ Oral corticosteroids.
  - ✓ Sulfasalazine.

Prior authorization requests for drugs for Crohn's disease must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Plaque Psoriasis

Enbrel® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat plaque psoriasis.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat plaque psoriasis are **all** of the following:

- The member has a diagnosis of plaque psoriasis and at least **one** of the following is true:
  - ✓ The member has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent or more of his or her body surface area.
  - ✓ The member has a diagnosis of palmoplantar psoriasis.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The member has received **two** or more of the following drugs and received each drug for at least **one** month and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Calcipotriene.
  - ✓ Tazarotene.
  - ✓ Topical corticosteroids.
- The member has received **one** or more of the following treatments and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction:
  - ✓ Cyclosporine.
  - ✓ Methotrexate.
  - ✓ Phototherapy.
  - ✓ Soriatane.

Prior authorization requests for drugs for plaque psoriasis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

Enbrel® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat psoriatic arthritis.

Simponi™ is a non-preferred drug used to treat psoriatic arthritis. For PA requests for Simponi™, the member must meet **all** clinical criteria below and have taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory

therapeutic response or experienced a clinically significant adverse drug reaction.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat psoriatic arthritis are **all** of the following:

- The member has a diagnosis of psoriatic arthritis.
- The member has moderate to severe symptoms of psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- At least **one** of the following is true:
  - ✓ The member has moderate to severe axial symptoms of psoriatic arthritis.
  - ✓ The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
    - Azathioprine.
    - Cyclosporine.
    - Hydroxychloroquine.
    - Leflunomide.
    - Methotrexate.
    - An NSAID or COX-2 inhibitor drug.
    - Oral corticosteroids.

Prior authorization requests for drugs for psoriatic arthritis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

Cimzia®, Enbrel®, and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat RA. Enbrel ®and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat polyarticular juvenile RA.

Kineret®, Orencia, and Simponi™ are non-preferred drugs used to treat RA. For PA requests for Kineret®, Orencia, and Simponi™, the member must meet **all** clinical criteria below and have taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. For PA requests for Simponi™, members must also continue to take methotrexate in combination with Simponi™.

Prior authorization requests for drugs for RA must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for RA and Polyarticular Juvenile RA.

Clinical Criteria for Rheumatoid Arthritis

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat RA are **all** of the following:

- The member has a diagnosis of RA.
- The member has moderate to severe symptoms of RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.
  - ✓ Oral corticosteroids.
  - ✓ Penicillamine.
  - ✓ Sulfasalazine.

Clinical Criteria for Polyarticular Juvenile Rheumatoid Arthritis

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat polyarticular juvenile RA are **all** of the following:

- The member has a diagnosis of polyarticular juvenile RA.

- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.
  - ✓ Oral corticosteroids.
  - ✓ Penicillamine.
  - ✓ Sulfasalazine.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

~~Enbrel®~~ Humira® is a preferred drug in the Cytokine and CAM antagonist drug class used to treat ulcerative colitis.

Clinical criteria for approval of a PA request for Humira® to treat ulcerative colitis are **all** of the following:

- The member has a diagnosis of ulcerative colitis.
- The member has moderate to severe symptoms of ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine).
  - ✓ 6-mercaptopurine (6MP).
  - ✓ Azathioprine.
  - ✓ Oral corticosteroids.

Prior authorization requests for Humira® for ulcerative colitis may be initially approved for up to three months.

Prior authorization requests may be approved for up to one year if the member has been using Humira® for ulcerative colitis for at least **two** consecutive months and the member has shown signs of clinical remission. For ongoing PA renewal requests, the member must continue to show evidence of clinical remission.

Xeljanz

Xeljanz will be a non-preferred drug in the cytokine and CAM antagonist drug class used to treat RA, which requires PA for Standard Plan, Medicaid, and SeniorCare members. Providers should submit PA requests for Xeljanz on paper using the PA/DGA and the PA/RF. Prior authorization forms are available on the Forms page of the Portal.

Quantity limits will apply to Xeljanz. Members will be limited to 68 tablets of Xeljanz per month. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Providers area of the Portal for the most current quantity limits.

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

Clinical Criteria for Xeljanz

Clinical criteria that must be documented for approval of a PA request for Xeljanz to treat RA are **all** of the following:

- The member is 18 years of age or older.
- The member has moderate to severe symptoms of RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken methotrexate for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has taken **one or more** of the following drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.

- ✓ Leflunomide.
- ✓ An NSAID or COX-2 inhibitor drug.
- ✓ Oral corticosteroids.
- ✓ Penicillamine.
- ✓ Sulfazalazine.

- The member has taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Prior authorization requests for Xeljanz must include documentation supporting that all of the clinical criteria have been met.

Initial PA requests for Xeljanz will be approved for up to 183 days. Renewal PA requests for Xeljanz will be approved for up to one year.

Glucocorticoids, Inhaled

Pulmicort Flexhaler will be added as a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members.

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

Hepatitis C Agents

Hepatitis C drugs in the alfa interferon, nucleoside analogues, and protease inhibitors drug classes will no longer be diagnosis-restricted drugs; therefore, diagnosis codes are no longer required on claims for hepatitis C agents. 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.

Multiple Sclerosis Agents, Immunomodulators

Drugs in the multiple sclerosis agents, immunomodulators drug class will no longer be diagnosis restricted; therefore, diagnosis codes are no longer required on claims for drugs in the multiple sclerosis agents, immunomodulators drug class. 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.

Aubagio® is a non-preferred drug in the multiple sclerosis, immunomodulators drug class that requires PA for Standard Plan, Medicaid, and SeniorCare members. Providers should submit PA requests for Aubagio® on paper using the PA/DGA and the PA/RF. Prior authorization forms are available on the Forms page of the Portal.

Aubagio® is not covered for Benchmark Plan, Core Plan, or Basic Plan members.

Clinical Criteria for Aubagio®

Clinical criteria that must be documented for approval of a PA request for Aubagio® are **all** of the following:

- The type of multiple sclerosis (MS) with which the member has been diagnosed.
- When the member was diagnosed with MS.
- The date of the member's last relapse and how complete the member's recovery was.
- Clinical information about why the member cannot use a preferred drug and why it is medically necessary that the member receive Aubagio® instead of a preferred MS immunomodulator drug, including at least **one** of the following:
  - ✓ The member has experienced an unsatisfactory therapeutic response with a preferred drug(s). If the member has experienced an unsatisfactory therapeutic response, indicate the preferred drug(s) and dose, specific details about the unsatisfactory therapeutic response, and the approximate dates the preferred drug(s) was taken.
  - ✓ The member has a medical condition(s) that prevents the use of a preferred drug(s). If the member has a medical condition(s) that prevents the use of a preferred drug(s), indicate the

member's medical condition(s) and the preferred drug(s).

- ✓ The member is taking a medication(s) with a clinically significant drug interaction with a preferred drug(s). If the member is taking a medication(s) with a clinically significant drug interaction, indicate the medication(s), the drug interaction(s), and the preferred drug(s).
- ✓ The member has experienced a clinically significant adverse drug reaction with a preferred drug(s). If the member has experienced a clinically significant adverse drug reaction, indicate the preferred drug(s) and dose, specific details about the clinically significant adverse drug reaction, and the approximate dates the preferred drug(s) was taken.

- Documentation of reliable birth control for women of childbearing age and for men with female partners of childbearing age.

Prior authorization requests for Aubagio® must include documentation supporting that all of the clinical criteria have been met.

Prior authorization requests for Aubagio® will only be approved for relapsing types of MS. Initial PA requests for Aubagio® may be approved for up to 183 days. Renewal PA requests for Aubagio® may be approved for up to one year.

Multiple Sclerosis Agents, Other

Ampyra continues to be diagnosis restricted. Providers may refer to the Diagnosis Restricted Drugs data table on the Portal for the most current list of allowable diagnosis codes.

Non-steroidal Anti-inflammatory Drugs

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Non-steroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, F-11077 (12/12). Providers may refer to Attachments 13 and 14 for a copy of the revised completion instructions and form.

There are no changes to preferred and non-preferred status of drugs in the NSAIDs drug class.

Clinical Criteria

The clinical criterion for approval of a PA request for a non-preferred NSAID, *excluding* COX-2 inhibitors and Celebrex®, is that the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred NSAIDs (the two preferred NSAIDs cannot be ibuprofen or naproxen).

Clinical criteria for approval of a PA request for Celebrex® require **one** of the following:

- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred NSAIDS (the two preferred NSAIDS cannot be ibuprofen or naproxen).
- The member has a history of familial adenomatous polyposis (FAP).
- The member has medical record documentation of thrombocytopenia or platelet dysfunction.
- The member has medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding.
- The member is currently taking oral anticoagulation therapy.
- The member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.
- The member is 65 years of age or older.

Ophthalmic Anti-inflammatories

Pred-Forte will no longer be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Pred-Forte will require brand medically necessary PA for Standard Plan, Medicaid, and SeniorCare members.

Providers are required to submit brand medically necessary PA requests for Pred-Forte on the Prior Authorization/ Brand Medically Necessary Attachment (PA/BMNA), F-11083 (07/12). Providers may refer to the Forms page of the

Portal for a copy of the PA/BMNA completion instructions and form.

Pred-Forte continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Ophthalmics, Allergic Conjunctivitis

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

ForwardHealth will no longer automatically apply the generic copayment or generic dispensing fee to claims for brand name Optivar.

Providers are required to submit brand medically necessary PA requests for Optivar on the PA/BMNA. Providers may refer to the Forms page of the Portal for a copy of the PA/BMNA completion instructions and form.

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

Optivar continues to be a noncovered drug for Benchmark Plan, Basic Plan, and Core Plan members. Azelastine hydrochloride continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Ophthalmics, Glaucoma — Other

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

Ophthalmics, Glaucoma — Prostaglandins

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

Otics, Antibiotics

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

Otics, Anti-infectives and Anesthetics

Acetic acid HC and acetic acid/aluminum will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Acetic acid HC and acetic acid/aluminum will be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

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

Acetic acid is covered for Benchmark Plan, Core Plan, and Basic Plan members. Providers may refer to the benefit plan-specific resources on the Portal for a list of drugs covered by each benefit plan.

Steroids, Topical (Low, Medium, High, and Very High)

Changes will be made to the preferred and non-preferred status of drugs in the steroids, topical low, medium, high, and very high drug classes. Providers may refer to the Preferred Drug List Quick Reference and benefit plan-specific product lists for the most current list of drugs covered by each plan.

Stimulants and Related Agents

Intuniv™ and Strattera® will be preferred drugs for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Age restrictions for Intuniv™ will no longer apply.

Intuniv™ and Strattera® continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

Concerta continues to be a preferred drug in the stimulants and related agents drug class, and its generic equivalent,

methylphenidate ER, will be a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Concerta continues to be a noncovered drug for Benchmark Plan and Basic Plan members, and its generic equivalent, methylphenidate ER, will be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

All drugs in the stimulants and related agents drug class continue to be diagnosis restricted. ForwardHealth has revised the list of allowed diagnosis codes for stimulants and related agents. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page of the Providers area of the Portal for the most current list of allowable diagnosis codes.

Revised Prior Authorization/Preferred Drug List for Stimulants and Related Agents Form

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Stimulants and Related Agents, F-11097 (12/12). Providers may refer to Attachments 15 and 16 for a copy of the revised completion instructions and form.

Clinical Criterion for Non-preferred Stimulants

The clinical criterion for approval of a PA request for a non-preferred stimulant is that the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants.

Clinical Criteria for Kapvay™

ForwardHealth has revised the clinical criteria for Kapvay™. Age restrictions for Kapvay™ no longer apply.

Kapvay™ continues to be a non-preferred drug in the stimulants and related agents drug class.

Clinical criteria for approval of a PA request for Kapvay require **one** of the following:

- The member will take Kapvay™ in combination with a preferred stimulant.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred stimulant.
- The member has a medical condition(s) preventing the use of a preferred stimulant.
- There is a clinically significant drug interaction between another medication the member is taking and a preferred stimulant.

Clinical Criteria for Modafinil

Prior authorization requests for modafinil for members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare should be submitted using the Prior Authorization Drug Attachment for Modafinil and Nuvigil®, F-00079 (12/12). This form was previously named the Prior Authorization Drug Attachment for Provigil and Nuvigil® form. The form has been revised and renamed. Providers may refer to Attachments 17 and 18 for a copy of the revised completion instructions and form.

Pharmacy providers may submit PA requests for modafinil by fax or mail. Prior authorization requests for modafinil cannot be submitted through the STAT-PA system.

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

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- For members with a diagnosis of narcolepsy:
  - ✓ A polysomnogram (PSG) has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - ✓ A multiple sleep latency test (MSLT) has been performed for the member. (*Note:* Test results for the MSLT must be submitted with the PA request.)

- For members with a diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS):
  - ✓ The member has tried a continuous positive airway pressure (CPAP) machine.
  - ✓ A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - ✓ The member's apnea-hypopnea index (AHI) measures more than five events per hour.
- For members with a diagnosis of shift work sleep disorder:
  - ✓ The member is a night shift worker.
  - ✓ The member is not currently taking hypnotics, sleep aids, or drugs that cause sleepiness.

Clinical criteria for approval of a PA request for modafinil for members with a diagnosis of attention deficit disorder or attention deficit hyperactivity disorder are the following:

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants.
  - ✓ The member has a medical history of substance abuse or misuse.
  - ✓ The member has a serious risk of drug diversion.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with Strattera®.

A dose limit continues to apply to modafinil. The dose limit for modafinil is 200 mg per day; any dose that exceeds the daily dose limit is a noncovered service. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Providers area of the Portal for the most current quantity limits.

Initial PA requests for modafinil may be approved for up to 183 days. Renewal PA requests for modafinil may be approved for up to one year.

Modafinil is not covered for Benchmark Plan or Basic Plan members.

Clinical Criteria for Nuvigil®

Prior authorization requests for Nuvigil for members enrolled in the Standard Plan, Medicaid, and SeniorCare should be submitted using the Prior Authorization Drug Attachment for Modafinil and Nuvigil® (refer to Attachments 17 and 18 for a copy of the revised completion instructions and form).

Pharmacy providers may submit PA requests for Nuvigil® by fax or mail. Prior authorization requests for Nuvigil® cannot be submitted through the STAT-PA system.

Members are required to have taken modafinil before PA may be requested for Nuvigil®. A member must have taken modafinil and experienced an unsatisfactory therapeutic response or had a clinically significant adverse drug reaction and be diagnosed with either narcolepsy, OSAHS, or shift work sleep disorder before PA may be requested for Nuvigil®.

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

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- For members with a diagnosis of narcolepsy:
  - ✓ A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - ✓ An MSLT has been performed for the member. (*Note:* Test results for the MSLT must be submitted with the PA request.)
- For members with a diagnosis of OSAHS:
  - ✓ The member has tried a CPAP machine.
  - ✓ A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - ✓ The member's AHI measures more than five events per hour.

- For members with a diagnosis of shift work sleep disorder:
  - ✓ The member is a night shift worker.
  - ✓ The member is not currently taking hypnotics, sleep aids, or drugs that cause sleepiness.

A dose limit continues to apply to Nuvigil®. The dose limit for Nuvigil® is 250 mg per day; any dose that exceeds the daily dose limit is a noncovered service. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Providers area of the Portal for the most current quantity limits.

Initial PA requests for Nuvigil® may be approved for up to 183 days. Renewal PA requests for Nuvigil® may be approved for up to one year.

Nuvigil® is not covered for Benchmark Plan, Basic Plan, or Core Plan members.

Pharmacy Policy Changes

Wisconsin AIDS/HIV Drug Assistance Program Form Revisions

With the addition of the Wisconsin ADAP to ForwardHealth in November 2012, ForwardHealth has revised the following forms:

- Drug Addition Review Request, F-00020 (10/12).
- Noncompound Drug Claim, F-13072 (10/12).
- Provider Change of Address or Status, F-01181 (10/12).

The revised forms are available on the Forms page of the Portal. ForwardHealth will accept older versions of these forms; however, providers are encouraged to begin using the revised forms immediately and discard older versions.

Anti-obesity Drugs

Qysmia is a new drug for anti-obesity available in the marketplace that has been approved by the Food and Drug Administration (FDA).

Prior authorization requests for anti-obesity drugs may be submitted on the Prior Authorization Drug Attachment for Anti-obesity Drugs, F-00163 (12/12). ForwardHealth has updated the clinical criteria for anti-obesity drugs and revised the Prior Authorization Drug Attachment for Anti-obesity Drugs form to reflect these changes. Providers may refer to Attachments 19 and 20 for a copy of the revised completion instructions and form.

As a reminder, PA requests for anti-obesity drugs must be submitted by prescribers or their designees, *not* pharmacy providers. Prescribers are encouraged to submit PA requests for anti-obesity drugs through the Drug Authorization and Policy Override (DAPO) Center. Prescribers may contact the DAPO Center at (800) 947-9627 from 8:00 a.m. to 5:30 p.m. (Central Standard Time), Monday through Friday, except holidays. Prior authorization requests for anti-obesity drugs may also be submitted on the Portal or on paper by fax or mail.

Clinical Criteria for Anti-obesity Drugs

Clinical criteria for approval of a PA request for anti-obesity drugs require **one** of the following:

- The member has a body mass index (BMI) greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 *and* two or more of the following risk factors:
  - ✓ Coronary heart disease.
  - ✓ Dyslipidemia.
  - ✓ Hypertension.
  - ✓ Sleep apnea.
  - ✓ Type II diabetes mellitus.

In addition, **all** of the following must be true:

- The member is 16 years of age or older. (*Note:* Members only need to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).

- The member does not have a medical contraindication to the selected medication.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

Prior authorization requests for anti-obesity drugs will not be renewed if a member's BMI is below 24.

Note: ForwardHealth does not cover the brand name (i.e., innovator) anti-obesity drug if an FDA-approved generic equivalent is available. In addition, ForwardHealth does not cover OTC anti-obesity drugs.

ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents as noncovered services.

Qysmia

If clinical criteria for anti-obesity drugs are met, initial PA requests for Qysmia will be approved for six months. If the member meets a weight loss goal of at least five percent of his or her weight from baseline, PA may be requested for an additional six months of treatment. Prior authorization requests for Qysmia may be approved for a maximum treatment period of 12 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least five percent of his or her weight from baseline during the initial six-month approval, or if the member has completed 12 months of continuous Qysmia treatment, the member must wait six months before PA can be requested for Qysmia, benzphetamine, diethylpropion, phendimetrazine, or phentermine.

ForwardHealth allows only two weight loss attempts with Qysmia during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

Benzphetamine, Diethylpropion, Phendimetrazine, and Phentermine

If clinical criteria for anti-obesity drugs are met, initial PA requests for benzphetamine, diethylpropion, phendimetrazine, and phentermine will be approved for three months. If the member meets a weight loss goal of at least 10 pounds during the initial three-month approval, PA may be requested for an additional three months of treatment. The maximum length of continuous drug therapy for benzphetamine, diethylpropion, phendimetrazine, and phentermine is six months.

If the member does not meet a weight loss goal of at least 10 pounds during the initial three-month approval, or if the member has completed six months of continuous benzphetamine, diethylpropion, phendimetrazine, or phentermine treatment, the member must wait six months before PA can be requested for Qysmia, benzphetamine, diethylpropion, phendimetrazine, or phentermine.

ForwardHealth allows only two weight loss attempts with this group of drugs (benzphetamine, diethylpropion, phendimetrazine, and phentermine) during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

Xenical®

If clinical criteria for anti-obesity drugs are met, initial PA requests for Xenical® will be approved for six months. If the member meets a weight loss goal of at least 10 pounds during the first six months of treatment, PA may be requested for an additional six months of treatment. If the member continues to lose weight, subsequent PA renewal periods for Xenical® are a maximum of six months. Prior authorization requests for Xenical® may be approved for a maximum treatment period of 24 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, if the member's weight increases during any renewal period, or if

the member has completed 24 months of continuous Xenical® treatment , the member must wait six months before PA can be requested for Xenical®.

ForwardHealth allows only two weight loss attempts with Xenical® during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

If a member has reached his or her goal weight and continues treatment with Xenical® to maintain weight loss, a PA request may be approved for a maximum of six months if the member does not gain weight during the PA renewal period and the maximum treatment period of 24 months of drug therapy is not exceeded.

Claims for Non-preferred Drugs

Pharmacy providers who submit real-time pharmacy claims for non-preferred drugs without an approved PA 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 will be included in the claim response. (For more information about NCPDP version D.0, refer to the NCPDP Payer Sheet version D.0, P-00272 [11/12], on the Trading Partners area of the Portal. From the Trading Partners page, providers may select Companion Guides from the bulleted list and then the P-00272 link.)

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 transaction.

Expedited Emergency Supply Policy Changes

As a result of changes made during the January 2013 PDL review, changes have been made to the Expedited Emergency Supply Request Drugs data table on the Pharmacy page of the Providers area of 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 on the Portal includes more information about dispensing an emergency supply of medication.

Medicare Part D Coverage of Barbiturates and Benzodiazepines

Effective for DOS on and after January 1, 2013, benzodiazepines will become Medicare Part D-covered drugs. Claims for benzodiazepines for dual eligibles should be submitted to Medicare Part D.

Effective for DOS on and after January 1, 2013, barbiturates will become Medicare Part D-covered drugs when used for cancer, epilepsy, or chronic mental health disorder diagnoses. Claims for barbiturates for dual eligibles should be submitted to Medicare Part D for members with these diagnoses.

Medicare Part D Claim Submission

BadgerCare Plus and Wisconsin Medicaid deny claims for Medicare Part D-covered drugs for dual eligibles. Claims and PA requests for Medicare Part D-covered drugs for dual eligibles must be submitted to the appropriate Medicare Part D Prescription Drug Plan (PDP). For dual eligibles enrolled in a PDP, providers may only submit claims to ForwardHealth for Medicare Part D-*excluded* drugs. All other claims will be denied, and the pharmacy provider will be instructed to submit the claim to the Medicare Part D PDP. Providers will receive an EOB code for this denial.

Medicare Part D-excluded drugs include barbiturates not used for a diagnosis of cancer, epilepsy, or a chronic mental health disorder; OTC drugs; agents that are used for the symptomatic relief of cough and cold; prescription vitamins and mineral products (except prenatal vitamins and fluoride); and weight loss agents.

Prior authorization requests for drugs covered by Medicare Part D will be denied because these drugs will be covered by a Medicare Part D PDP.

Note: Because SeniorCare coordinates benefits with Medicare Part D, SeniorCare covers Medicare Part D-excluded drugs and accepts PA requests for drugs for SeniorCare members in all levels of participation who are enrolled in a Medicare Part D PDP.

State-Contracted MCOs or HMOs

Drug claims for dual eligibles enrolled in state-contracted managed care organizations (MCOs) or HMOs should be handled in the same way as claims for dual eligibles who receive drug coverage from fee-for-service.

Claims for barbiturates not used for a diagnosis of cancer, epilepsy, or a chronic mental health disorder; OTC drugs; agents that are used for the symptomatic relief of cough and cold; prescription vitamins and mineral products (except prenatal vitamins and fluoride); and weight loss agents may be submitted to fee-for-service for dual eligible MCO or HMO enrollees.

SeniorCare

Pharmacy providers are required to submit claims for SeniorCare members who are enrolled in a Medicare Part D PDP to the member's PDP and other health insurance sources before submitting claims to SeniorCare. SeniorCare is a payer of last resort.

Providers are required to submit claims to the appropriate PDP for members in all levels of participation. Providers are also required to indicate the outcome of the claim response from the PDP to SeniorCare.

Pharmacy providers are required to report to SeniorCare any out-of-pocket expenses (i.e., coinsurance, deductible, copayment) determined by the primary insurance. SeniorCare calculates and issues reimbursement, if applicable, for the claim submitted by the pharmacy.

Enddating Prior Authorizations via STAT-PA

Effective on and after January 1, 2013, providers may enddate PAs using the STAT-PA system according to the following requirements:

- The PA must be for a drug.
- The provider must be the provider who obtained PA and must have the provider number used to obtain the PA.
- The PA must have been approved through STAT-PA initially.
- Prior authorization for the drug can be submitted through STAT-PA currently.
- The end date must be after the grant date and before the expiration date.
- The PA must *not* have been previously amended.
- The end date must be within 14 days of the current date.
- The end date must be within 29 days of the services (days' supply) that are already used on the PA. For PAs for Suboxone®, the end date must be within 10 days.

Providers may continue to submit amendment requests using the Portal or on paper by fax or mail.

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 attachment and supporting documentation received from the prescriber.

For More Information

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

Information Regarding Managed Care Organizations

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

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 AIDS/HIV Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

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

P-1250

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ulcerative Colitis Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ULCERATIVE COLITIS 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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis, F-00694. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Ulcerative Colitis 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR ULCERATIVE COLITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has a diagnosis of ulcerative colitis.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of ulcerative colitis.

Element 15
Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

Element 16
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member is currently using Humira® for ulcerative colitis. If yes, complete Section IIIA of the form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING HUMIRA® FOR ULCERATIVE COLITIS

Element 18
Check the appropriate box to indicate whether or not the member has been using Humira® for ulcerative colitis for at least the past two months.

Element 19
Check the appropriate box to indicate whether or not the member has shown evidence of clinical remission since starting Humira®.

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 request 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 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 product requested may be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ulcerative Colitis" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ULCERATIVE COLITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis Instructions, F-00694A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR ULCERATIVE COLITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of ulcerative colitis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of ulcerative colitis?	❑ Yes	❑ No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR ULCERATIVE COLITIS (Continued)

16. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

1. ❑ oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine) _____
2. ❑ 6-mercaptopurine (6MP) _____
3. ❑ azathioprine _____
4. ❑ oral corticosteroids _____

17. Is the member currently using Humira® for ulcerative colitis? ❑ Yes ❑ No

If yes, complete Section IIIA of this form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING HUMIRA® FOR ULCERATIVE COLITIS

18. Has the member been using Humira® for ulcerative colitis for at least the past two months? ❑ Yes ❑ No

19. Has the member shown evidence of clinical remission since starting Humira®? ❑ Yes ❑ No

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 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 product requested may be included here.

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS 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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has a diagnosis of ankylosing spondylitis.

Element 14
Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

Element 15
Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of ankylosing spondylitis.

Element 16
Check the appropriate box to indicate whether or not the member has received **one** or more of the drugs listed on the PA/PDL form and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the box next to the drug(s) the member received and indicate the dose of the drug(s), specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s), and the approximate dates the drug(s) was taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.

Element 17
Check the appropriate box to indicate whether or not the member has taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the two preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — 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 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply, up to 365 days.

Element 22 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 23 — 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 24 — 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 25 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Enter the date the PA request was approved by the STAT-PA system.

Element 27 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 28 — Number of Days Approved
Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 29
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11304 (12/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions, F-11304A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of ankylosing spondylitis?	❑ Yes	❑ No
14. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
15. Does the member have moderate to severe axial symptoms of ankylosing spondylitis?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS (Continued)

16. Has the member received **one** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the box next to the drug(s) the member received. Indicate the dose of the drug(s), specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s), and the approximate dates the drug(s) was taken in the space provided.

1. ❑ leflunomide _____
2. ❑ methotrexate _____
3. ❑ NSAID or COX-2 _____
4. ❑ oral corticosteroids _____
5. ❑ sulfasalazine _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

17. Has the member taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the two preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates each preferred cytokine and CAM antagonist drug was taken in the space provided.

1. _____
2. _____

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 digits)	21. Days' Supply Requested (Up to 365 Days)

22. NPI

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

24. Place of Service

25. Assigned PA Number

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE 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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has a diagnosis of Crohn's disease.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of Crohn's disease.

Element 15
Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

Element 16
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 17 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 18 — 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 19 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 20 — Days' Supply Requested
Enter the requested days' supply.

Element 21 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 22 — 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 23 — 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 24 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 25 — Grant Date
Enter the date the PA request was approved by the STAT-PA system.

Element 26 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 27 — Number of Days Approved
Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 28
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 6
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Completion Instructions, F-11305A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE

12. Diagnosis Code and Description

13. Does the member have a diagnosis of Crohn's disease?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of Crohn's disease?	❑ Yes	❑ No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE (Continued)

16. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

1. ❑ 5-aminosalicylic (5-ASA) _____
2. ❑ 6-mercaptopurine (6MP) _____
3. ❑ azathioprine _____
4. ❑ methotrexate _____
5. ❑ oral corticosteroids _____
6. ❑ sulfasalazine _____

SECTION IV — AUTHORIZED SIGNATURE

17. **SIGNATURE** — Prescriber	18. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

19. National Drug Code (11 digits)	20. Days' Supply Requested (Up to 365 Days)

21. NPI

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

23. Place of Service

24. Assigned PA Number

25. Grant Date	26. Expiration Date	27. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 7
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS 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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has a diagnosis of plaque psoriasis.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area.

Element 15
Check the appropriate box to indicate whether or not the member has a diagnosis of palmoplantar psoriasis.

Element 16
Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or through a dermatology consultation.

Element 17
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **one** month and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the box next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse reactions, and the approximate dates the drugs were used in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member has received **one** or more of the treatments listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction. If yes, check the box next to the treatment(s) the member received and indicate the dose of the treatment(s), specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse reaction(s), and the approximate date(s) of the treatments in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 19 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 20 — 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 21 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 22 — Days' Supply Requested
Enter the requested days' supply, up to 365 days.

Element 23 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 24 — 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 25 — 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 26 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 27 — Grant Date
Enter the date the PA request was approved by the STAT-PA system.

Element 28 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 29 — Number of Days Approved
Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 30
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 8
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11306 (12/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions, F-11306A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of plaque psoriasis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area?	❑ Yes	❑ No
15. Does the member have a diagnosis of palmoplantar psoriasis?	❑ Yes	❑ No
16. Is the prescription written by a dermatologist or through a dermatology consultation?	❑ Yes	❑ No

Continued

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SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS (Continued)

17. Has the member received **two** or more of the drugs listed below and received each drug for at least **one** month and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the box next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were used in the space provided.

1. ❑ calcipotriene _____
2. ❑ tazarotene _____
3. ❑ topical corticosteroids _____

18. Has the member received **one** or more of the treatments listed below and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction? ❑ Yes ❑ No

If yes, check the box next to the treatment(s) the member received. Indicate the dose of the treatment(s), specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse reaction(s), and the approximate date(s) of the treatment(s) in the space provided.

1. ❑ cyclosporine _____
2. ❑ methotrexate _____
3. ❑ phototherapy _____
4. ❑ Soriatane _____

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 digits)	22. Days' Supply Requested (Up to 365 Days)

23. NPI

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

25. Place of Service

26. Assigned PA Number

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

Continued

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 9
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS 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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has a diagnosis of psoriatic arthritis.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of psoriatic arthritis.

Element 15
Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.

Element 16
Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of psoriatic arthritis.

Element 17
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted in paper.

Element 18
Check the appropriate box to indicate whether or not the member has taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 19 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 20 — 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 21 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 22 — Days' Supply Requested
Enter the requested days' supply, up to 365 days.

Element 23 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 24 — 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 25 — 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 26 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 27 — Grant Date
Enter the date the PA request was approved by the STAT-PA system.

Element 28 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 29 — Number of Days Approved
Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 30
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 10
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11307 (12/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions, F-11307A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of psoriatic arthritis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of psoriatic arthritis?	❑ Yes	❑ No
15. Is the prescription written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation?	❑ Yes	❑ No
16. Does the member have moderate to severe axial symptoms of psoriatic arthritis?	❑ Yes	❑ No

Continued

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SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS (Continued)

17. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space below.

1. ❑ azathioprine _____
2. ❑ cyclosporine _____
3. ❑ hydroxychloroquine _____
4. ❑ leflunomide _____
5. ❑ methotrexate _____
6. ❑ NSAID or COX-2 _____
7. ❑ oral corticosteroids _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

18. Has the member taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the two preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates each preferred cytokine and CAM antagonist drug was taken in the space provided.

1. _____
2. _____

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 digits)	22. Days' Supply Requested (Up to 365 Days)

23. NPI

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

25. Place of Service

26. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 11
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis [RA] and Polyarticular Juvenile RA Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA) AND POLYARTICULAR JUVENILE RA 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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA, F-11308. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for RA and Polyarticular Juvenile RA 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR RA AND POLYARTICULAR JUVENILE RA

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has a diagnosis of polyarticular juvenile RA.

Element 14
Check the appropriate box to indicate whether or not the member has a diagnosis of RA.

Element 15
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of RA.

Element 16
Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

Element 17
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONST DRUG REQUESTS

Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.

Element 18

Check the appropriate box to indicate whether or not the member has taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the two preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS

Element 19

Check the appropriate box to indicate whether or not the member will continue to take methotrexate in combination with Simponi.

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 request 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 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 product requested may be included here.

ATTACHMENT 12
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis [RA] and Polyarticular Juvenile RA" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11308 (12/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA) AND POLYARTICULAR JUVENILE RA

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA Completion Instructions, F-11308A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile Rheumatoid Arthritis (RA) 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE RA (Required for all requests.)

12. Diagnosis Code and Description

13. Does the member have a diagnosis of polyarticular juvenile RA?	❑ Yes	❑ No
14. Does the member have a diagnosis of RA?	❑ Yes	❑ No
15. Does the member have moderate to severe symptoms of RA?	❑ Yes	❑ No
16. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR RA AND POLYARTICULAR JUVENILE RA (Continued)

17. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space below.

1. ❑ azathioprine _____
2. ❑ cyclosporine _____
3. ❑ hydroxychloroquine _____
4. ❑ leflunomide _____
5. ❑ methotrexate _____
6. ❑ NSAIDs or COX-2 _____
7. ❑ oral corticosteroids _____
8. ❑ penicillamine _____
9. ❑ sulfasalazine _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

18. Has the member taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the two preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

1. _____

2. _____

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS

19. Will the member continue to take methotrexate in combination with Simponi? ❑ Yes ❑ No

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 or up to 14 days in the past.)

Continued

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

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 product requested may be included here.

ATTACHMENT 13
Prior Authorization/Preferred Drug List (PA/PDL) for Non-steroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Nonsteroidal Anti-inflammatory Drugs [NSAIDs], Including Cyclo-oxygenase Inhibitors, Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-OXYGENASE INHIBITORS, COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information applies to Medicaid and SeniorCare.

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 applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Non-steroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, F-11077. Pharmacy providers are required to use the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors 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, prescribers can 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

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

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

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

Element 2 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for NSAIDS, Including Cyclo-oxygenase Inhibitors, form. For PA requests for cyclo-oxygenase inhibitors, providers are also required to complete Section IIIA.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred NSAIDs. (The two preferred NSAIDs taken cannot include ibuprofen or naproxen.) If yes, list the preferred NSAIDs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred NSAIDs were taken in the space provided.

SECTION IIIA — CLINICAL INFORMATION FOR CYCLO-OXYGENASE INHIBITORS ONLY

Element 14
Check the appropriate box to indicate whether or not the member has a history of familial adenomatous polyposis (FAP).

Element 15
Check the appropriate box to indicate whether or not the member has medical record documentation of thrombocytopenia or platelet dysfunction.

Element 16
Check the appropriate box to indicate whether or not the member has medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding.

Element 17
Check the appropriate box to indicate whether or not the member is currently taking oral anticoagulation therapy.

Element 18
Check the appropriate box to indicate whether or not the member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.

Element 19
Check the appropriate box to indicate whether or not the member is 65 years of age or older.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply.

Element 22 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 23 — 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 24 — 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 25 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 27 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 28 — 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 29 — Signature — Prescriber
The prescriber is required to complete and sign this form.

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 14
Prior Authorization/Preferred Drug List (PA/PDL) for Nonsteroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Non-steroidal Anti-inflammatory Drugs [NSAIDs], Including Cyclo-oxygenase Inhibitors" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-OXYGENASE INHIBITORS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Non-steroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, Completion Instructions, F-11077A. 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 Non-steroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Providers are required to complete Section III. For PA requests for cyclo-oxygenase inhibitors, providers are also required to complete Section IIIA.)

12. Diagnosis Code and Description

13. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred NSAIDs? (The two preferred NSAIDs taken cannot include ibuprofen or naproxen.) ❑ Yes ❑ No

If yes, list the preferred NSAIDs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred NSAIDs were taken in the space provided.

1. _____
2. _____
3. _____
4. _____

Continued

SECTION IIIA — CLINICAL INFORMATION FOR CYCLO-OXYGENASE INHIBITORS ONLY

14. Does the member have a history of familial adenomatous polyposis (FAP)?	❑ Yes	❑ No
15. Does the member have medical record documentation of thrombocytopenia or platelet dysfunction?	❑ Yes	❑ No
16. Does the member have medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding?	❑ Yes	❑ No
17. Is the member currently taking oral anticoagulation therapy?	❑ Yes	❑ No
18. Has the member been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy?	❑ Yes	❑ No
19. Is the member 65 years of age or older?	❑ Yes	❑ No

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 Digits)	21. Days' Supply Requested (Up to 365 Days)

22. NPI

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

24. Place of Service

25. Assigned PA Number

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION V — AUTHORIZED SIGNATURE

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 15
Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents, F-11097. Pharmacy providers are required to use the PA/PDL for Stimulants and Related 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION
If this section is completed, providers do not need to submit a copy of the prescription.

Element 4 — Drug Name
Enter the drug name.

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS
Providers are required to complete the appropriate sections before signing and dating the PA/PDL for Stimulants and Related Agents form. Providers are required to complete Section III and either Section IIIA or Section IIIB.

Element 12 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Kapvay.)

Element 13
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants. If yes, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR KAPVAY REQUESTS ONLY

Element 14
Check the appropriate box to indicate whether or not the member will take Kapvay in combination with a preferred stimulant. If yes, list the preferred stimulant in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred stimulant. If yes, list the preferred stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred stimulant was taken in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has a medical condition preventing the use of a preferred stimulant. If yes, list the medical condition(s) that prevents the use of a preferred stimulant in the space provided.

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

SECTION IV — AUTHORIZED SIGNATURE

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — 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 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply up to 365 days.

Element 22 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 23 — 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 24 — 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 25 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 27 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 28 — Number of Days Approved
Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 29
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 16
Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, F-11097A. 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 Stimulants and Related 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. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS (Providers are required to complete Section III and either Section IIIA or Section IIIB.)

12. Diagnosis Code and Description

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Kapvay.)

13. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants? ❑ Yes ❑ No

If yes, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

1. _____
2. _____
3. _____
4. _____

Continued

SECTION IIIB — CLINICAL INFORMATION FOR KAPVAY REQUESTS ONLY

14. Will the member take Kapvay in combination with a preferred stimulant? ❑ Yes ❑ No

If yes, list the preferred stimulant in the space provided.

15. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred stimulant? ❑ Yes ❑ No

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

16. Does the member have a medical condition(s) preventing the use of a preferred stimulant? ❑ Yes ❑ No

If yes, list the medical condition(s) that prevents the use of a preferred stimulant in the space provided.

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

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

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 Digits)	21. Days' Supply Requested (Up to 365 Days)

22. NPI

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

24. Place of Service

25. Assigned PA Number

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

29. 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 17
Prior Authorization Drug Attachment for Modafinil and Nuvigil Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MODAFINIL AND NUVIGIL® COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS
Attach the completed Prior Authorization Drug Attachment for Modafinil and Nuvigil® form, F-00079, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests on paper by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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

Note: Nuvigil® is not covered by the BadgerCare Plus Core Plan.

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
Providers should check only the name and strength of the drug for which PA is being requested.

Element 4 — Modafinil Drug Strength
Check the strength of drug in milligrams.

Element 5 — Nuvigil® Drug Strength
Check the strength of drug in milligrams.

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

Element 7 — Directions for Use
Enter the directions for use of the drug.

Element 8 — Refills
Enter the number of refills.

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

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

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

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

SECTION III — CLINICAL INFORMATION
Providers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Modafinil and Nuvigil® form. Providers are required to complete Section III and either Section IIIA, IIIB, IIIC, or IIID.

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 is at least 16 years old.

Element 15
Check the appropriate box to indicate whether or not the member is currently taking any other stimulants.

Element 16
For requests for Nuvigil®, check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to modafinil. If yes, indicate specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, the dose of modafinil, and the approximate dates modafinil was taken in the space provided. (If the request is for modafinil, check “N/A.”)

SECTION IIIA — CLINICAL INFORMATION FOR NARCOLEPSY

Element 17
Check the appropriate box to indicate whether or not the member has a diagnosis of narcolepsy.

Element 18
Check the appropriate box to indicate whether or not the member has completed a polysomnogram (PSG). If yes, the results from a PSG **must** be submitted with this PA request for consideration.

Element 19
Check the appropriate box to indicate whether or not the member has taken a multiple sleep latency test (MSLT). If yes, the results from an MSLT **must** be submitted with this PA request for consideration.

SECTION IIIB — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME

Element 20
Check the appropriate box to indicate whether or not the member has a diagnosis of obstructive sleep apnea/hypopnea syndrome.

Element 21
Check the appropriate box to indicate whether or not the member has completed a PSG. If yes, the results from a PSG **must** be submitted with this PA request for consideration.

Element 22
Check the appropriate box to indicate the member’s Apnea-Hypopnea Index in events per hour.

Element 23
Check the appropriate box to indicate whether or not the member has tried continuous positive airway pressure.

SECTION IIIC — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

Element 24 Check the appropriate box to indicate whether or not the member has a diagnosis of shift work sleep disorder.

Element 25
Check the appropriate box to indicate whether or not the member is a night-shift worker.

Element 26
Check the appropriate box to indicate whether or not the member is taking any hypnotics, sleep aids, or other medications that can cause sleepiness.

Element 27
Enter the member's current employer, along with his or her weekly work schedule.

SECTION IIID — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (Complete this section only for PA requests for modafinil.)

Element 28
Check the appropriate box to indicate whether or not the member has a diagnosis of attention deficit disorder or attention deficit hyperactivity disorder.

Element 29
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants. If yes, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

Element 30
Check the appropriate box to indicate whether or not the member has previously taken Strattera and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates Strattera was taken in the space provided.

Element 31
Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse. If yes, explain in the space provided.

Element 32
Check the appropriate box to indicate whether or not the member poses a risk of drug diversion. If yes, explain in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 33 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 34 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 35
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 18
Prior Authorization Drug Attachment for Modafinil and Nuvigil

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00079 (12/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MODAFINIL AND NUVIGIL®

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Modafinil and Nuvigil® Completion Instructions, F-00079A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Modafinil and Nuvigil® form signed by the prescriber before submitting a prior authorization (PA) request. Providers may call Provider Services at (800) 947-9627 with questions.

Nuvigil® is not covered for BadgerCare Plus Core Plan members.

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. Modafinil Drug Strength (Check one only. If a box is checked in this element, do not check a box in Element 5.)
   ❑ 100 mg ❑ 200 mg

5. Nuvigil® Drug Strength (Check one only. If a box is checked in this element, do not check a box in Element 4.)
   ❑ 50 mg ❑ 150 mg ❑ 250 mg

6. Date Prescription Written

7. Directions for Use

8. Refills

9. Name — Prescriber

10. National Provider Identifier — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Providers are required to complete Section III and either Section IIIA, IIIB, IIIC, or IIID before signing and dating this form.)

13. Diagnosis Code and Description

14. Is the member at least 16 years old? ❑ Yes ❑ No

15. Is the member taking any other stimulants? ❑ Yes ❑ No

16. For requests for Nuvigil®: Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to modafinil? (If the request is for modafinil, check "N/A.") ❑ Yes ❑ No ❑ N/A

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

SECTION IIIA — CLINICAL INFORMATION FOR NARCOLEPSY

17. Does the member have a diagnosis of narcolepsy? ❑ Yes ❑ No

18. Has the member had a polysomnogram (PSG)? ❑ Yes ❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR NARCOLEPSY (Continued)

19. Has the member had a multiple sleep latency test (MSLT)? ❑ Yes ❑ No

The results from the PSG and MSLT **must** be submitted with this PA request for consideration.

SECTION IIIB — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA / HYPOPNEA SYNDROME

20. Does the member have a diagnosis of obstructive sleep apnea / hypopnea syndrome (OSAHS)? ❑ Yes ❑ No

21. Has the member had a PSG? ❑ Yes ❑ No

22. What is the member's Apnea-Hypopnea Index (AHI)? _____ Events / Hour

23. Has the member tried continuous positive airway pressure (CPAP)? ❑ Yes ❑ No

The results from the PSG **must** be submitted with this PA request for consideration.

SECTION IIIC — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

24. Does the member have a diagnosis of shift work sleep disorder? ❑ Yes ❑ No

25. Is the member a night-shift worker? ❑ Yes ❑ No

26. Is the member taking any hypnotics, sleep aids, or other medications that can cause sleepiness? ❑ Yes ❑ No

27. State the member's employer and weekly work schedule.

SECTION IIID — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (Complete this section only for PA requests for modafinil.)

28. Does the member have a diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)? ❑ Yes ❑ No

29. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants? ❑ Yes ❑ No

If yes, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

1. _____
2. _____
3. _____
4. _____

30. Has the member previously taken Strattera 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 Strattera was taken in the space provided.

31. Does the member have a medical history of substance abuse or misuse? ❑ Yes ❑ No

If yes, explain in the space provided.

Continued

SECTION IIID — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (Continued)

32. Does the member have a serious risk of drug diversion? ❑ Yes ❑ No

If yes, explain in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

33. **SIGNATURE** — Prescriber	34. Date Signed

SECTION V — ADDITIONAL INFORMATION

35. 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 19
Prior Authorization Drug Attachment for Anti-obesity Drugs Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Anti-obesity Drugs Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Anti-Obesity Drugs form, F-00163, to request PA for anti-obesity drugs. Prescribers are required to retain a completed copy of the form.

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

1) For requests submitted through the Drug Authorization and Policy Override Center, prescribers may call (800) 947-9627.

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

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

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

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER AND PROVIDER 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.

Element 4 — Name — Prescriber
Enter the name of the prescriber.

Element 5 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 6 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 8 — Name — Billing Provider
Enter the name of the billing provider. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI as the billing provider on the PA request. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-enrolled billing provider (e.g., clinic) with which they are affiliated on the PA request.

Element 9 — NPI — Billing Provider
Enter the 10-digit NPI of the billing provider.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name
Enter the drug name.

Element 11 — Drug Strength
Enter the strength of the drug listed in Element 10.

Element 12 — Date Prescription Written
Enter the date the prescription was written.

Element 13 — Directions for Use
Enter the directions for use of the drug.

Element 14 — Refills
Enter the number of refills.

SECTION III — CLINICAL INFORMATION

Providers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Anti-obesity Drugs form.

Element 15 — 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 16 — Height — Member
Enter the member's height in inches.

Element 17 — Weight — Member
Enter the member's weight in pounds.

Element 18 — Date Member's Weight Was Measured
Enter the date the member's weight was measured in MM/DD/CCYY format.

Element 19 — Body Mass Index (BMI) — Member
Enter the member's current body mass index (BMI) using the following equation.

$$\text{BMI} = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$$

Example: Height = 5'9"
Weight = 230 lbs
Figure out height in inches: 5 x 12 = 60 + 9 = 69

$$\text{BMI} = \frac{703 \times 230}{69^2} \qquad \text{BMI} = \frac{161690}{4761} \qquad \text{BMI} = 33.96$$

Element 20 — Goal Weight — Member
Enter the member's goal weight in pounds. This should be a number agreed upon by the prescribing medical practitioner and the member.

SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS
Complete this section for initial and renewal requests for anti-obesity drugs.

Element 21
Check the appropriate box to indicate whether or not the member is pregnant or nursing.

Element 22
Check the appropriate box to indicate whether or not the member has a history of an eating disorder (e.g., anorexia, bulimia).

Element 23
Check the appropriate box to indicate the medication prescribed for the member. In addition, answer the questions below the drug name that apply to the member's medical history.

SECTION IIIB — INITIAL COVERAGE REQUIREMENTS
Complete this section for initial requests for anti-obesity drugs.

Element 24
Check the appropriate box to indicate whether or not the member's BMI is greater than or equal to 30 or greater than or equal to 27 but less than 30 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, or type II diabetes mellitus. If applicable, indicate the member's current risk factors.

Element 25
Check the appropriate box to indicate whether or not the member has participated in a weight loss treatment plan in the past six months and if the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

Element 27 — Date Signed — Prescriber
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 28
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

SECTION VI — INTERNAL USE ONLY
This section is for internal use only.

ATTACHMENT 20
Prior Authorization Drug Attachment for Anti-obesity Drugs

(A copy of the "Prior Authorization Drug Attachment for Anti-obesity Drugs" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00163 (12/12)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

Instructions: Type or print clearly. Before completing this form, read Prior Authorization Drug Attachment for Anti-Obesity Drugs Completion Instructions, F-00163A. 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.

Prescribers are required to complete the Prior Authorization Drug Attachment for Anti-obesity Drugs form before submitting a prior authorization request. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER AND PROVIDER INFORMATION

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

2. Member Identification Number	3. Date of Birth — Member
4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber
6. Address — Prescriber (Street, City, State, ZIP+4 Code)	7. Telephone Number — Prescriber
8. Name — Billing Provider	9. NPI — Billing Provider

SECTION II — PRESCRIPTION INFORMATION

10. Drug Name	11. Drug Strength
12. Date Prescription Written	13. Directions for Use

14. Refills

SECTION III — CLINICAL INFORMATION

15. Diagnosis Code and Description

16. Height — Member (Inches)	17. Weight — Member (Pounds)
18. Date Member's Weight Was Measured	19. Body Mass Index (BMI) — Member (lb / in^2)
20. Goal Weight — Member (Pounds)	BMI = $\frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$

For an initial drug request, the provider should complete Section IIIA and Section IIIB. For a renewal drug request, the provider should complete Section IIIA.

SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

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

Continued

DT-PA085-085

SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS (Continued)

22. Does the member have a history of an eating disorder (e.g., anorexia, bulimia)? ❑ Yes ❑ No

23. Medication Contraindications (Check either A or B and answer the questions that follow.)

A. ❑ Xenical (orlistat).

- ❑ Does the member have chronic malabsorption syndrome? ❑ Yes ❑ No
- ❑ Does the member have cholestasis? ❑ Yes ❑ No

B. ❑ Central nervous system (CNS) stimulant-type anti-obesity drugs (i.e., benzphetamine, diethylpropion, phendimetrazine, phentermine, Qsymia).

- ❑ Does the member have glaucoma? ❑ Yes ❑ No
- ❑ Does the member have hyperthyroidism? ❑ Yes ❑ No
- ❑ Does the member have advanced arteriosclerosis? ❑ Yes ❑ No
- ❑ Does the member have a history of drug abuse or misuse? ❑ Yes ❑ No
- ❑ Does the member have uncontrolled hypertension? ❑ Yes ❑ No
- ❑ Is the member hypersensitive to any sympathomimetic amines? ❑ Yes ❑ No

SECTION IIIB — INITIAL COVERAGE REQUIREMENTS

24. Body Mass Index Requirements (Check A or B.)

A. ❑ The member's BMI is greater than or equal to 30.

B. ❑ The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors. Check the member's current risk factors.

- ❑ Coronary Heart Disease.
- ❑ Dyslipidemia.
- ❑ Hypertension.
- ❑ Sleep Apnea.
- ❑ Type II Diabetes Mellitus.

25. Has the member participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will the member continue to follow this treatment plan while taking an anti-obesity drug? ❑ Yes ❑ No

If yes, describe the treatment plan in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — ADDITIONAL INFORMATION

28. 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.

SECTION VI — INTERNAL USE ONLY

- ❑ Initial request.
- ❑ Renewal request (Xenical).
- ❑ Renewal request (CNS stimulant-type anti-obesity drugs — benzphetamine, diethylpropion, phendimetrazine, phentermine).
- ❑ Renewal request (CNS stimulant-type anti-obesity drugs — Qysmia).