ForwardHealth
Wisconsin serving you

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

July 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 July 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 July 1, 2013, unless otherwise noted.

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

A Comprehensive Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee on whether certain PDL drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness of the drug, clinical outcomes, and the relative cost of the drug (to Wisconsin Medicaid) in comparison with other therapeutically interchangeable alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Medicaid PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Most drugs and drug classes included on the PDL are covered by the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, but certain drugs may have restrictions (e.g., diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA except in designated classes identified on the Preferred Drug List Quick Reference. Noncovered drugs

(e.g., drugs used for hair loss or cosmetic purposes) are not reimbursed, even with PA.

Starting a member on a medication by using manufacturer-provided samples may not be used to circumvent PA policy. Use of manufacturer-provided samples does not provide claim history documentation regarding the dose of a medication that was taken or compliance with treatment so it will not be considered as previous medication history for PA review.

A Prescriber's 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 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.

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.

Clinical Criteria for Non-preferred Drugs

Clinical criteria for approval of a PA request for a non-preferred drug are at least **one** of the following, unless drug class-specific clinical criteria have been established and published by ForwardHealth:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the preferred drugs from the same PDL drug class as the drug being requested.
- There is a clinically significant drug interaction between another drug the member is taking and at least one of the preferred drugs from the same PDL drug class as the drug being requested.
- The member has a medical condition(s) that prevents the use of at least one of the preferred drugs from the same PDL drug class as the drug being requested.

Additional Clinical Criteria for Non-preferred Drugs in Eligible Drug Classes Only

The following drug classes have additional clinical criteria that may be considered for approval of a PA request for a non-preferred drug:

- Alzheimer's agents drug class.
- Anticonvulsants drug class.
- Antidepressants, other drug class.
- Antidepressants, SSRI drug class.
- Antiparkinson's agents drug class.
- Antipsychotics drug class.
- HIV-AIDS drug class.
- Pulmonary arterial hypertension drug class.

Additional clinical criteria that may be considered for approval of a PA request for a non-preferred drug in one of these drug classes are **one** of the following:

- The member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member had an approved PA issued by ForwardHealth that recently expired for the non-preferred drug, and the member has taken the

requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.

- The member was recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested.

Completing a Prior Authorization Form

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, or the member may carry the form with the prescription to the pharmacy. 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.

A Pharmacy Provider's 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 choose to 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, by fax, or by 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.

Revised Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) Exemption Request, F-11075 (07/13). Copies of the revised completion instructions and form are included in Attachments 1 and 2 of this *Update*. Prescribers are required to complete the PA/PDL Exemption Request for non-preferred drugs that do not have specific clinical criteria requirements. Prior authorization requests processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

New Drug Classes

The following drug classes will be added to the PDL on July 1, 2013:

- H2 antagonists drug class.
- Irritable bowel syndrome drug class.

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

H2 Antagonists

The following will be preferred drugs in the H2 antagonists drug class for Standard Plan, Medicaid, and SeniorCare members and continue to be covered drugs for Benchmark Plan, Core Plan, and Basic Plan members:

- Cimetidine solution.
- Cimetidine tablets.
- Famotidine tablets.
- Ranitidine syrup.
- Ranitidine tablets.

The following will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members:

- Axid® solution.
- Famotidine suspension.
- Nizatidine capsules.
- Nizatidine solution.
- Ranitidine capsules.

Ranitidine capsules will be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members. Axid® solution, famotidine suspension, nizatidine capsules, and nizatidine solution continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Over-the-counter (OTC) H2 antagonists continue to be noncovered drugs for Standard Plan, Medicaid, SeniorCare, Benchmark Plan, Core Plan, and Basic Plan members.

Famotidine Suspension

Famotidine suspension will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Prior authorization is not required for famotidine suspension for Standard Plan and Medicaid members who are 18 years of age or younger. For Standard Plan, Medicaid, and SeniorCare members 19 years of age or older, PA is required for famotidine suspension.

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

Irritable Bowel Syndrome Drugs

Amitiza® will be a preferred drug in the irritable bowel syndrome drug class for Standard Plan, Medicaid, and SeniorCare members. Amitiza® continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

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

Analgesics, Narcotics Short

Combination products containing hydrocodone/acetaminophen with either 325 mg or 500 mg of acetaminophen continue to be preferred drugs for Standard Plan, Medicaid, and SeniorCare members and continue to be covered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Combination products containing hydrocodone/acetaminophen with any other strength of acetaminophen will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members and will be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members. (For example, a combination of hydrocodone 5 mg/acetaminophen 300 mg would be non-preferred for Standard Plan, Medicaid, and SeniorCare members and would be noncovered for Benchmark Plan, Core Plan, and Basic Plan members.)

Oxycodone and Zydone® capsules will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Oxycodone capsules will no longer be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members. Zydone® capsules continue to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Androgenic Agents

Androderm® will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Androderm® continues to be a noncovered drug for Benchmark Plan and Basic Plan members. Androderm® will no longer be covered for Core Plan members.

Angiotensin Modulators

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

Antibiotics, Inhaled

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Medicaid PA Advisory Committee. Therefore, TOBI® Podhaler™ will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. TOBI® Podhaler™ continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

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

Prior authorization requests for TOBI® Podhaler™ and Cayston must be completed and signed by prescribers. Prior authorization requests for TOBI® Podhaler™ and Cayston should be submitted 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 the use of TOBI® Podhaler™ or Cayston must be submitted with the PA request. Prior authorization forms are available on the Forms page of the Portal.

Prior authorization requests for TOBI® Podhaler™ and Cayston may be submitted on the Portal, by fax, or by mail. Prior authorization requests for TOBI® Podhaler™ and Cayston may **not** be submitted via STAT-PA.

ForwardHealth has established clinical criteria for coverage of TOBI® Podhaler™ and revised the clinical criteria for Cayston.

Clinical Criteria for TOBI® Podhaler™

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

- The member has a diagnosis of cystic fibrosis.
- The member is six years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. (Prescribers are required to include a copy of the sputum culture report with all PA requests.)
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's forced expiratory volume in 1 second (FEV1) is less than 90 percent predicted. (Prescribers are required to include the member's FEV1, FEV1 predicted, and FEV1 percent predicted, along with the dates taken.)
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. Providers should provide a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.
- The prescriber has submitted detailed clinical justification for prescribing TOBI® Podhaler™ instead of Tobi inhalation solution, including clinical information why the member cannot use Tobi inhalation solution and why it is medically necessary that the member receive TOBI® Podhaler™ instead of Tobi inhalation solution.

Clinical Criteria for Cayston

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

- The member has a diagnosis of cystic fibrosis.
- The member is six years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. (Prescribers are required to include a copy of the sputum culture report with all PA requests.)
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's FEV1 is less than 90 percent predicted. (Prescribers are required to include the member's FEV1, FEV1 predicted, and FEV1 percent predicted, along with the dates taken.)
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. Providers should provide a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.
- At least **one** of the following is true:
  - ✓ The member has previously used Tobi inhalation solution and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response.
  - ✓ The member has a medical condition(s) that prevents the use of Tobi inhalation solution.
  - ✓ The member's sputum culture shows resistance to tobramycin.

  Prescribers should indicate the specific details about the clinically significant adverse drug reaction(s), the unsatisfactory therapeutic response(s), or the medical condition(s) preventing the member from using Tobi inhalation solution.

The following indicate how PA requests for TOBI® Podhaler™ and Cayston will be approved when clinical criteria have been met:

- Prior authorization requests will be approved for up to a maximum of a 28-day supply per dispensing.
- Prior authorization requests will be approved with an alternating month treatment schedule of one month of TOBI® Podhaler™ or Cayston treatment with one month of no inhaled antibiotics/anti-infective agents.
- Prior authorization requests may be approved for up to a maximum of 168 days.

Antibiotics, Tetracyclines

Doxycycline monohydrate 50 mg and 100 mg capsules continue to be preferred drugs for Standard Plan, Medicaid, and SeniorCare members and continue to be covered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Other strengths of doxycycline monohydrate capsules will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members and will be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

Anticoagulants

The anticoagulants drug class will be subdivided into two subclasses:

- The anticoagulants, injectable drug class.
- The anticoagulants, oral drug class.

Anticoagulants, Injectable

The anticoagulants, injectable drug class includes the following drugs:

- Arixtra®.
- Enoxaparin.
- Fondaparinux.
- Fragmin® syringe.
- Fragmin® vial.
- Lovenox®.

Note: There are no changes to the status of these drugs.

Anticoagulants, Oral

Pradaxa® will be a preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Pradaxa® will be a noncovered drug for Benchmark Plan and Basic Plan members. Pradaxa® will no longer be a diagnosis-restricted drug.

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

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

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

Note: Quantity limits continue to apply to this drug class. Refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy Resources page of the Providers area of the Portal for the most current quantity limits.

New Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral Form

ForwardHealth has created a new form, the Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral, F-00806 (07/13), and established clinical criteria for coverage of oral anticoagulants. Prior authorization requests for oral anticoagulants may be submitted on the PA/PDL for Anticoagulants, Oral form for DOS on and after July 1, 2013. Providers may refer to Attachments 3 and 4 for a copy of the completion instructions and form.

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

Clinical Criteria for Non-Preferred Anticoagulants, Oral

Clinical criteria for approval of a PA request for a non-preferred oral anticoagulant are **both** of the following:

- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Pradaxa®.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and Pradaxa®.
- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Xarelto®.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and Xarelto®.

Antiemetics, Cannabinoids

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids, F-00194 (07/13). Providers may refer to Attachments 5 and 6 for a copy of the revised completion instructions and form.

Prior authorization requests for antiemetic, cannabinoid drugs may be submitted on the Portal, by fax, or by mail. Prior authorization requests for antiemetic, cannabinoid drugs may **not** be submitted via STAT-PA.

Prior authorization requests for antiemetic, cannabinoid drugs may be approved for up to a maximum of 183 days.

Clinical Criteria for Marinol®

Clinical Criteria for Marinol® for HIV- and AIDS-Related Weight Loss or Cachexia

Clinical criteria for approval of a PA request for Marinol® for the treatment of weight loss or cachexia caused by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) for members who are **not** currently receiving Marinol® are **all** of the following:

- **One** of the following is true:
  - ✓ The member's baseline weight is typically in the normal weight range or above, and either the member's current body mass index (BMI) falls into

the underweight range or the member had a 20 percent or greater decrease in weight from baseline in the past six months.
    - ✓ The member's baseline weight is normally in the underweight range and the member has had a five percent or greater decrease in weight from baseline.
- The member's daily caloric intake has been optimized.
- The member has been advised on and is following an appropriate dietary plan.

Clinical criteria for approval of a PA request for Marinol® for the treatment of weight loss or cachexia caused by HIV or AIDS for members who are currently receiving Marinol® are **both** of the following:

- The member's BMI is **not** in the overweight or obese range.
- **One** of the following is true:
    - ✓ The member's BMI remains in the underweight range.
    - ✓ The member's BMI has been stabilized in the normal range for less than six months.

Note: Members whose weight has been stabilized in the normal range for at least six months will **not** be granted a Marinol® PA renewal.

Clinical Criteria for Marinol® for Chemotherapy-Related Nausea and Vomiting

Clinical criteria for approval of a PA request for Marinol® for the treatment of chemotherapy-related nausea and vomiting are **both** of the following:

- At least **one** of the following is true:
    - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with ondansetron.
    - ✓ There is a clinically significant drug interaction between another drug(s) the member is taking and ondansetron.
- The member has a medical condition(s) that prevents the use of ondansetron.
- At least **one** of the following is true:
    - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Emend®.
    - ✓ There is a clinically significant drug interaction between another drug(s) the member is taking and Emend®.
    - ✓ The member has a medical condition(s) that prevents the use of Emend®.

Clinical Criteria for Cesamet

Clinical criteria for approval of a PA request for Cesamet are **all** of the following:

- The member is experiencing chemotherapy-related nausea and vomiting.
- At least **one** of the following is true:
    - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with ondansetron.
    - ✓ There is a clinically significant drug interaction between another drug(s) the member is taking and ondansetron.
    - ✓ The member has a medical condition(s) that prevents the use of ondansetron.
- At least **one** of the following is true:
    - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Emend®.
    - ✓ There is a clinically significant drug interaction between another drug(s) the member is taking and Emend®.
    - ✓ The member has a medical condition(s) that prevents the use of Emend®.

Clinical Criteria for Dronabinol

Clinical criteria for approval of a PA request for dronabinol are **both** of the following:

- The member meets all of the clinical criteria for Marinol®.
- The prescriber has submitted detailed clinical justification for prescribing dronabinol instead of Marinol®, including clinical information why the

member cannot use Marinol® and why it is medically necessary that the member receive dronabinol instead of Marinol®.

Antiparasitics, Topical

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

Antivirals, Oral

Amantadine tablets and syrup continue to be preferred drugs for Standard Plan, Medicaid, and SeniorCare members and continue to be covered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

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

Beta Blockers

Brand name Toprol XL® continues to be a preferred drug, in addition to other preferred drugs, in the beta blockers drug class for Standard Plan, Medicaid, and SeniorCare members. Generic metoprolol ER will change from a preferred drug to a non-preferred drug and will require PA effective July 1, 2013. Toprol XL® will continue to **not** require brand medically necessary PA. ForwardHealth will continue to automatically apply the generic copayment and a generic dispensing fee on claims for Toprol XL®.

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

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

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

Bone Resorption Suppression and Related Agents

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

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

Note: Miacalcin® will no longer qualify for the generic copayment and dispensing fee that ForwardHealth applies to brand name drugs that are preferred over their generic equivalents.

Calcitonin-salmon continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Calcitonin-salmon continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Note: Members who are currently taking Miacalcin® or calcitonin-salmon should be switched to preferred Fortical® unless it is not clinically appropriate. Pharmacies should work with prescribers to begin switching members.

Benign Prostatic Hyperplasia Treatments

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

Calcium Channel Blocking Agents

Cardizem LA® will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Cardizem® LA

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

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

Fentanyl Mucosal Agents

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents, F-00281 (07/13). Providers may refer to Attachments 7 and 8 for a copy of the revised completion instructions and form. Prior authorization requests processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

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

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

Clinical Criteria for Fentanyl Mucosal Agents

Clinical criteria for approval of a PA request for a fentanyl mucosal agent are **all** of the following:

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

Growth Hormone Drugs

Nutropin®, Nutropin AQ®, and Norditropin® continue to be preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Nutropin®, Nutropin AQ®, and Norditropin® continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

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

Note: Saizen® will continue to be covered for members who have an approved PA on file with ForwardHealth dated prior to July 1, 2013, until that PA expires.

HIV-AIDS

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

Prior authorization requests for Stribild™ must be completed and signed by prescribers. Prior authorization requests for Stribild™ should be submitted using the PA/DGA and the PA/RF. Clinical documentation supporting the use of Stribild™ must be submitted with the PA request.

Prior authorization requests for Stribild™ may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Stribild™ may **not** be submitted via STAT-PA.

ForwardHealth has revised the clinical criteria for approval of a PA request for Stribald™.

Clinical Criteria for Stribild™

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

- The member is treatment naïve to antiretroviral therapy (ART).
- The member's estimated creatinine clearance (CrCl) is 70 ml/min or greater.
- The prescriber has submitted detailed clinical justification why Stribild™ is the preferred ART

regimen for the member and has indicated specific factors that were considered in choosing Stribild™.

Initial PA requests for Stribild™ may be approved for up to a maximum of 183 days. Renewal requests may be approved for up to a maximum of one year.

H. Pylori Treatment

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

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

Hypoglycemics, Glucagon-Like Peptide Agents

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

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents, F-00238 (07/13). Providers may refer to Attachments 9 and 10 for a copy of the revised completion instructions and form. Prior authorization requests processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

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

Prior authorization requests for Bydureon and Victoza may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Bydureon and Victoza may **not** be submitted via STAT-PA.

Prior authorization requests for GLP-1 agents may be initially approved for up to a maximum of 183 days. Prior authorization requests may be approved for up to a maximum of one year if the member has been using a GLP-1 agent for at least six months and the member's hemoglobin A1c (HbA1c) decreased by at least 0.5 percent from the member's initial HbA1c or if the member's HbA1c was above seven percent and the HbA1c dropped below seven percent. For ongoing PA renewal requests, the member must continue to maintain the improved HbA1c value.

Clinical Criteria for Byetta

Clinical criteria for approval of a PA request for Byetta are **all** of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is **not** currently being treated with rapid-acting, short-acting, intermediate-acting, or premixed insulin injections.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member's HbA1c was measured within the past six months.
- If the member is **not** currently using a GLP-1 agent, his or her most recent HbAc1 is 6.5 percent or greater.
- If the member is **not** being treated with long-acting insulin (e.g., Lantus, Levemir®), **one** of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.

- ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
- ✓ The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
- ✓ The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.

- If the member is being treated with long-acting insulin (e.g., Lantus, Levemir®), **one** of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin.
  - ✓ The member is unable to take the maximum effective dose of metformin.

Clinical Criteria for Bydureon

Clinical criteria for approval of a PA request for Bydureon are **all** of the following:

- The member has type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is **not** currently being treated with any insulin.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member's HbA1c was measured within the past six months.
- If the member is **not** currently using a GLP-1 agent, his or her most recent HbAc1 is 6.5 percent or greater.
- **One** of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective does of a sulfonylurea.
  - ✓ The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
  - ✓ The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
- The member has taken the maximum dose of Byetta for at least three consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

Clinical Criteria for Victoza

Clinical criteria for approval of a PA request for Victoza are **all** of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is **not** currently being treated with rapid-acting, short-acting, intermediate-acting, or premixed insulin injections.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member's HbA1c was measured within the past six months.

- If the member is **not** currently using a GLP-1 agent, his or her most recent HbAc1 is 6.5 percent or greater.
- If the member is **not** being treated with long-acting insulin (e.g. Lantus, Levemir®), **one** of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
  - ✓ The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
  - ✓ The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
- If the member is being treated with long-acting insulin (e.g., Lantus, Levemir®), **one** of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin.
  - ✓ The member is unable to take the maximum effective dose of metformin.
- The member has taken the maximum dose of Byetta for at least three consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

Hypoglycemics, Incretin/Mimetic Enhancers

Janumet® XR and Juvisync™ will be preferred drugs for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Janumet® XR and Juvisync™ continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

Kombiglyze™ XR and Onglyza® will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members.

Kombiglyze™ XR and Onglyza® will become noncovered drugs for Core Plan members. Kombiglyze™ XR and Onglyza® continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

Hypoglycemics, Insulins

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

Hypoglycemics, Thiazolidinediones

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

Duetact® and Actoplus Met® will be non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members. Duetact® and Actoplus Met® will be noncovered drugs for Core Plan members and continue to be noncovered drugs for Benchmark Plan and Basic Plan members.

Lipotropics, Omega-3 Acids

Lovaza® will be a preferred drug that requires clinical PA for Standard Plan, Medicaid, and SeniorCare members. Lovaza® continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

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

Note: Clinical PA is required for all omega-3 acids, including preferred omega-3 acids.

Prior Authorization Drug Attachment for Lovaza® Form Has Been Revised and Renamed

Prior authorization requests for Lovaza® and Vascepa® for Standard Plan, Medicaid, and SeniorCare members should be submitted using the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids, F-00162 (07/13). This form was previously named the Prior Authorization Drug Attachment for Lovaza® form. The form has been revised and renamed. Providers may refer to Attachments 11 and 12 for a copy of the revised completion instructions and form. Prior authorization requests processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

Submitting Prior Authorization Requests for Omega-3 Acids

Prior authorization requests for omega-3 acids must be submitted by prescribers or their designees, **not** pharmacy providers.

Prior authorization requests for omega-3 acids may be submitted through the following:

- The Drug Authorization and Policy Override (DAPO) Center at (800) 947-9627. Prescribers may contact the DAPO Center from 8:00 a.m. to 5:30 p.m. (Central Standard Time), Monday through Friday, except holidays.

  Note: Prior authorization requests for omega-3 acids submitted by fax or mail will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

- The Portal at *www.forwardhealth.wi.gov/*.
- Fax to (608) 221-8616.
- Mail to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  313 Blettner Blvd
  Madison WI 53784

Prior authorization request submission procedures apply to members enrolled in the Standard Plan, Medicaid, and SeniorCare.

Prior Authorization Requests Submitted by Fax or Mail

If a prescriber or his or her designee chooses to submit a PA request for an omega-3 acid by fax or mail, the following must be completed and submitted to ForwardHealth:

- A PA/RF (which should be completed using the instructions for prescribers for drugs).
- The Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet, F-01176 (12/11) is available on the Forms page of the Portal for providers submitting the forms and documentation by fax.

Clinical Criteria for Lovaza®

Clinical criteria for approval of a PA request for Lovaza® for members who are **not** currently taking Lovaza® are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.

- **One** of following is true:
  - ✓ The member currently has a triglyceride level of 500 mg/dL or greater.
  - ✓ The member currently has a triglyceride level **below** 500 mg/dL and **both** of the following are true:
    - o The member has had a triglyceride level of 500 mg/dL or greater in the past.
    - o The member has a current triglyceride level between 200 and 499 mg/dL while taking a fibrate or niacin. (If a member's triglyceride level is below 200mg/dL, the PA request will be denied.)

Clinical criteria for approval of a PA request for Lovaza® for members who are currently taking Lovaza® are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- The member's current triglyceride level has decreased by at least 20 percent from the baseline level.
- The member has had a triglyceride level of 500 mg/dL or greater in the past.

Clinical Criteria for Non-preferred Omega-3 Acids

Clinical criteria for approval of a PA request for a non-preferred omega-3 acid for members **not** currently taking a non-preferred omega-3 acid are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- In the past year, the member has taken the maximum dose of Lovaza® for at least four consecutive months and **one** of the following is true:
  - ✓ The member failed to achieve at least a 30 percent decrease in triglyceride level from the baseline.
  - ✓ The member's triglyceride level remained at 500 mg/dL or greater.
- **One** of following is true:
  - ✓ The member currently has a triglyceride level of 500 mg/dL or greater.
  - ✓ The member currently has a triglyceride level **below** 500 mg/dL and **both** of the following are true:
    - o The member has had a triglyceride level of 500 mg/dL or greater in the past.
    - o The member has a current triglyceride level between 200 and 499 mg/dL while taking a fibrate, niacin, or Lovaza®. (If a member's triglyceride level is below 200 mg/dL, the PA request will be denied.)

Clinical criteria for approval of a PA request for a non-preferred omega-3 acid for members currently taking a non-preferred omega-3 acid are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- The member's current triglyceride level has decreased by at least 20 percent from the baseline level.
- The member has had a triglyceride level of 500 mg/dL or greater in the past.

Approved Prior Authorization Requests for Omega-3 Acids

Prior authorization requests for omega-3 acids may be initially approved for four months. Renewal PA requests may be approved for up to a maximum of one year. For an **initial renewal** PA request to be approved, the member's triglyceride levels must decrease by at least 20 percent from the baseline triglyceride level. For **subsequent renewal** PA requests to be approved, the member must continue to maintain the improved triglyceride level.

Lipid panels, including triglyceride levels, within the previous three months are required for each yearly PA renewal request thereafter.

Macrolides/Ketolides

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

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

Migraine Agents, Injectable

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

Sumatriptan injectable continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members and continues to be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

All PA requests for non-preferred injectable migraine agents must be submitted using the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable, F-00622 (06/12). Pharmacy providers may refer to the Forms page of the Portal for copies of the completion instructions and form.

Clinical Criteria for Non-Preferred Migraine Agents, Injectable

As a reminder, clinical criteria for approval of a PA request for a non-preferred injectable migraine agent are **all** of the following:

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

Migraine Agents, Other

Rizatriptan tablets will be a preferred drug, in addition to other preferred drugs, for Standard Plan, Medicaid, and SeniorCare members. Rizatriptan tablets will be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Rizatriptan, orally disintegrating tablets (ODTs) will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Prior authorization is not required for rizatriptan, ODTs for Standard Plan and Medicaid members who are 12 years of age or younger. For Standard Plan, Medicaid, and SeniorCare members 13 years of age or older, PA is required for rizatriptan, ODTs.

Rizatriptan, ODTs continue to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Revised Prior Authorization/Preferred Drug List for Migraine Agents, Other Form

Prior authorization requests for non-preferred migraine agents must be submitted on the Prior Authorization/ Preferred Drug List (PA/PDL) for Migraine Agents, Other, F-00280 (07/13). This form has been revised. Providers may refer to Attachments 13 and 14 for a copy of the revised completion instructions and form. Prior authorization requests processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

Prior authorization requests for non-preferred migraine agents may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Prior authorization requests for non-preferred migraine agents may be approved for up to a maximum of one year.

ForwardHealth has revised the clinical criteria for non-preferred migraine agents.

Clinical Criterion for Non-preferred Migraine Agents, Other

The **sole clinical criterion** for approval of a PA request for a non-preferred migraine agent is that the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least **three** preferred drugs from the Migraine Agents, Other drug class.

Multiple Sclerosis Agents, Immunomodulators

New Prior Authorization/Preferred Drug List for Multiple Sclerosis Agents, Immunomodulators Form

ForwardHealth has created a new form, the Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators, F-00805 (07/13), and established clinical criteria for coverage of immunomodulators to treat MS. Prior authorization requests for immunomodulators to treat MS may be submitted on the PA/PDL for MS Agents, Immunomodulators form for DOS on and after July 1, 2013. Providers may refer to Attachments 15 and 16 for a copy of the completion instructions and form.

Pharmacy providers may submit PA requests for immunomodulators to treat MS using the STAT-PA system, on the Portal, by fax, or by mail.

Clinical Criteria for Non-preferred Immunomodulators to Treat Multiple Sclerosis

Clinical criteria for approval of a PA request for a non-preferred immunomodulator to treat MS are **both** of the following:

- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the preferred MS interferons: Avonex®, Betaseron, or Rebif.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and at least one of the preferred MS interferons: Avonex®, Betaseron, or Rebif.
  - ✓ The member has a medical condition(s) that prevents the use of at least one of the preferred MS interferons: Avonex®, Betaseron, or Rebif.
- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Copaxone.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and Copaxone.
  - ✓ The member has a medical condition(s) that prevents the use of Copaxone.

Multiple Sclerosis Agents, Other

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

continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members. Ampyra® continues to be diagnosis restricted. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy Resources page of the Providers area of the Portal for the most current list of allowable diagnosis codes.

Prior authorization requests for Ampyra® must be completed and signed by prescribers. Prior authorization requests for Ampyra® should be submitted using the PA/DGA and the PA/RF. Clinical documentation supporting the use of Ampyra® must be submitted with the PA request. Prior authorization requests for Ampyra® may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Ampyra® may **not** be submitted via STAT-PA.

Initial PA requests for Ampyra® may be approved for up to a maximum of 183 days. If walking improves, renewal PA requests for Ampyra® may be approved for up to a maximum of one year.

ForwardHealth has revised the clinical criteria for Ampyra®.

Clinical Criteria for Ampyra®

Clinical criteria that must be documented for approval of an initial PA request for Ampyra® are **both** of the following:

- The member has been diagnosed with MS.
- The member is able to walk.

Clinical information that must be documented on both initial and renewal PA requests for Ampyra® are the following:

- The type of MS with which the member has been diagnosed.
- The member's walking ability, including:
  - ✓ Distance the member is able to walk.
  - ✓ Length of time the member is able to walk.
  - ✓ Assistive devices the member uses.
  - ✓ How the member's walking ability is being measured.
  - ✓ The date the member's walking ability was last measured (must be within the past three months).

Providers are required to measure the member's walking ability before PA is requested for Ampyra®, prior to the renewal of a PA request for Ampyra® at six months of treatment, and at least yearly when the member is taking Ampyra®. For renewal PA requests for Ampyra®, **both** of the above criteria must be met, and the member's ability to walk must show improvement while on Ampyra®.

Opioid Dependency Agents

Suboxone ® film continues to be a preferred drug that requires clinical PA for Standard Plan, Core Plan, Medicaid, and SeniorCare members. Suboxone ® film is a noncovered drug for Benchmark Plan and Basic Plan members.

Buprenorphine-naloxone tablets will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members.

Buprenorphine-naloxone tablets will be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

Prior Authorization/Preferred Drug List (PA/PDL) for Suboxone® and Buprenorphine Form Has Been Revised and Renamed

Prior authorization requests for opioid dependency agents for Standard Plan, Medicaid, and SeniorCare members must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents form, F-00081 (07/13). This form was previously named the Prior Authorization/Preferred Drug List for Suboxone® and Buprenorphine 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. Prior authorization requests processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

Submitting Prior Authorization Requests for Opioid Dependency Agents

Prior authorization requests for Suboxone® film and buprenorphine tablets for Standard Plan, Medicaid, and SeniorCare members may be submitted using the STAT-PA system, on the Portal, by fax, or by mail. Prior authorization requests for Suboxone® film and buprenorphine tablets for Core Plan members may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Suboxone® film and buprenorphine tablets for Core Plan members may **not** be submitted via STAT-PA.

Prior authorization requests for buprenorphine-naloxone tablets for Standard Plan, Medicaid, and SeniorCare members may be submitted on the Portal, by fax, or by mail. Prior authorization requests for buprenorphine-naloxone tablets for Standard Plan, Medicaid, and SeniorCare members may **not** be submitted via STAT-PA.

Prior authorization requests for opioid dependency agents may be approved for up to a maximum of 183 days.

Clinical Criteria for Suboxone® Film

Clinical criteria for approval of a PA request for Suboxone® film are **all** of the following:

- The member has a diagnosis of opioid type dependence.
- The member is 16 years of age or older.
- The drug is being prescribed by a physician who has obtained a Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone® or buprenorphine for opioid dependence.
- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.
- The prescribing physician has indicated that he or she has read the attestation statement on the form and that he or she agrees to follow guidelines set forth by the U.S. Department of Health and Human Services (HHS) Federation of State Medical Boards — Model Policy Guidelines for Opioid Addiction Treatment.

Clinical Criteria for Buprenorphine Tablets

Clinical criteria for approval of a PA request for buprenorphine tablets are **all** of the following:

- The member has a diagnosis of opioid type dependence.
- The member is 16 years of age or older.
- The drug is being prescribed by a physician who has obtained a DATA 2000 waiver allowing him or her to prescribe Suboxone® or buprenorphine for opioid dependence.
- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.
- The prescribing physician has indicated that he or she has read the attestation statement on the form and that he or she agrees to follow guidelines set forth by the U.S. HHS Federation of State Medical Boards — Model Policy Guidelines for Opioid Addiction Treatment.
- The member is nursing or pregnant.
- The prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant and nursing women.
- The prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant and nursing women.

Clinical Criteria for Buprenorphine-Naloxone Tablets

Clinical criteria for approval of a PA request for buprenorphine-naloxone tablets are **all** of the following:

- The member has a diagnosis of opioid type dependence.
- The member is 16 years of age or older.

- The drug is being prescribed by a physician who has obtained a DATA 2000 waiver allowing him or her to prescribe Suboxone® or buprenorphine for opioid dependence.
- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.
- The prescribing physician has indicated that he or she has read the attestation statement on the form and that he or she agrees to follow guidelines set forth by the U.S. HHS Federation of State Medical Boards — Model Policy Guidelines for Opioid Addiction Treatment.
- The provider has submitted detailed clinical justification why the member cannot use Suboxone® film and why it is medically necessary that the member receive buprenorphine-naloxone tablets instead of Suboxone® film.

Phosphate Binders

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

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

Proton Pump Inhibitors

Nexium suspension will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Nexium suspension will be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

The following suspensions will remain preferred drugs in the proton pump inhibitors (PPI) drug class for Standard Plan, Medicaid, and SeniorCare members and continue to be noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members:

- Prilosec suspension.
- Protonix suspension.

Prevacid® solutab 15 mg continues to be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members. Prevacid® solutab 15 mg continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members. An age exemption no longer applies to Prevacid® solutab 15 mg; therefore, PA is required for Prevacid® solutab 15 mg regardless of the member's age.

Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets Form Has Been Revised and Renamed

Prior authorization requests for PPI drugs may be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets form, F-11078 (10/11), or the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets form, F-00433 (07/13). The PA/PDL for PPI Orally Disintegrating Tablets form was previously named the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets form. The form has been revised and renamed. Providers may refer to Attachments 19 and 20 for a copy of the revised completion instructions and form. Providers may refer to the Forms page of the Portal for a copy of the PA/PDL for PPI Capsules and Tablets completion instructions and form.

Prior authorization requests for PPI orally disintegrating tablets that are processed on and after July 1, 2013, must be submitted on the revised form or they will be returned.

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

Clinical Criteria for Proton Pump Inhibitor Orally Disintegrating Tablets

Clinical Criteria for Members Who Can *Take Oral Suspensions*

Clinical criteria for approval of a PA request for PPI orally disintegrating tablets for members who **can** take oral suspensions are **all** of the following:

- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction on any dosage form of esomeprazole.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and esomeprazole.
- At least **on**e of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction on any dosage form of omeprazole.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and omeprazole.
- At least **one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction on any dosage form of pantoprazole.
  - ✓ There is a clinically significant drug interaction between another drug the member is taking and pantoprazole.

Note: Pantoprazole criteria do **not** apply to members under 5 years of age. Only esomeprazole criteria and omeprazole criteria apply to members under 5 years of age.

Clinical Criteria for Members Who Cannot *Take Oral Suspensions*

Clinical criteria for approval of a PA request for PPI orally disintegrating tablets for members who **cannot** take oral suspensions are **both** of the following:

- The member has a medical condition(s) that prevents the use of PPI suspensions.
- Member preference is **not** the reason why the member is unable to take PPI suspensions.

Pulmonary Arterial Hypertension Agents

Sildenafil (generic of Revatio®) will be a preferred drug for Standard Plan, Medicaid, and SeniorCare members. Sildenafil will be a covered drug for Benchmark Plan, Core Plan, and Basic Plan members. For members currently grandfathered on Revatio®, grandfathering will end effective for DOS on and after July 1, 2013. Revatio® continues to be a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members.

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

Ulcerative Colitis Agents

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

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Medicaid PA Advisory Committee; therefore, Delzicol will be a non-preferred drug for Standard Plan, Medicaid, and SeniorCare members.

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

Expedited Emergency Supply

As a result of changes made during the July 2013 PDL review, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page of the Providers area of the Portal has been updated. The Emergency Medication Dispensing topic (topic #1399) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook includes more information about dispensing an emergency supply of medication.

Reminders

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

Diagnosis Restrictions

Prescribers are required to indicate a diagnosis on prescriptions for all drugs that are identified by ForwardHealth as diagnosis-restricted. If a diagnosis is not indicated on the prescription, pharmacy providers should contact the prescriber to obtain the diagnosis and document the diagnosis on the prescription or pharmacy health care record. It is not acceptable for pharmacy providers to obtain the diagnosis from the member.

The diagnosis submitted on a claim must also be verifiable within the member's prescription record or pharmacy health care record. Upon retrospective review, ForwardHealth may seek recoupment for the payment of the prescription from the pharmacy if the prescription record or pharmacy health care record does not document that the diagnosis submitted on the claim was provided by the prescriber.

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.

Pharmacy Resources

As a reminder, ForwardHealth continues to monitor such policies as opioid drug prescription fill limits, quantity limits, and early refill limits. For more information about covered drugs and pharmacy policy, providers may refer to the resources available on the Pharmacy Resources page of the Providers area of the Portal. Providers may also refer to the Pharmacy service area of the Online Handbook on the Portal for more information about pharmacy 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.

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

This *Update* was issued on 06/20/2013 and information contained in this *Update* was incorporated into the Online Handbook on 07/16/2013.

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST 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) Exemption Request, F-11075. Pharmacy providers are required to use the PA/PDL Exemption Request 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL Exemption Request form.

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

Element 13
Enter the PDL drug class to which the requested non-preferred drug belongs (e.g., COPD agents) from the PDL quick reference.

Element 14
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction while taking at least one of the preferred drugs from the same PDL drug class as the drug being requested. If yes is checked, indicate the preferred drug(s) that caused the unsatisfactory therapeutic response or adverse drug reaction, the dates the preferred drug(s) was taken, and describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) in the space provided.

Element 15
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and at least one of the preferred drugs from the same PDL drug class as the drug being requested. If yes is checked, indicate the drug(s) and interaction(s) in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents the use of at least one of the preferred drugs from the same PDL drug class as the drug being requested. If yes is checked, list the member's medical condition(s) and describe how the condition(s) prevents the member from using the preferred drug(s) in the space provided.

SECTION IV — ADDITIONAL CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY

Element 17
Check the appropriate box for the drug class of the non-preferred drug being requested.

Element 18
Check the appropriate box to indicate if the member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month). If yes is checked, indicate the month and year the member became eligible in the space provided.

Element 19
Check the appropriate box to indicate whether or not the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response. If yes is checked, indicate the month and year the member began taking the drug in the space provided.

Element 20
Check the appropriate box to indicate whether or not the member was recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested. If yes is checked, indicate the facility name and the month and year of discharge in the space provided.

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

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

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

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

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

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

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

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

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

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request

(A copy of the "Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, F-11075A. 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) Exemption Request 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, by fax, or by mail. 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 (Required for all PA requests.)

12. Diagnosis Code and Description

13. List the PDL drug class to which the requested non-preferred drug belongs (e.g., COPD agents).

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the preferred drugs from the same PDL drug class as the drug being requested? ❑ Yes ❑ No

If yes, list the preferred drug(s) used. _____

List the dates the preferred drug(s) was taken. _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and at least one of the preferred drugs from the same PDL drug class as the drug being requested? ❑ Yes ❑ No

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

16. Does the member have a medical condition(s) that prevents the use of at least one of the preferred drugs from the same PDL drug class as the drug being requested? ❑ Yes ❑ No

    If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred drug(s) in the space provided.

SECTION IV — ADDITIONAL CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY

17. Indicate the drug class.

- ❑ Alzheimer's Agents
- ❑ Anticonvulsants
- ❑ Antidepressants, Other
- ❑ Antidepressants, SSRI
- ❑ Antiparkinson's Agents
- ❑ Antipsychotics
- ❑ HIV-AIDS
- ❑ Pulmonary Arterial Hypertension

18. Is the member new to ForwardHealth (i.e., has this member been granted eligibility for ForwardHealth within the past month)? ❑ Yes ❑ No

    If yes, indicate the month and year the member became eligible in the space provided. ___ ___ / ___ ___ ___ ___ (Month / Year)

19. Has the member taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response? ❑ Yes ❑ No

    If yes, indicate the month and year the member began taking the drug in the space provided. ___ ___ / ___ ___ ___ ___ (Month / Year)

20. Was the member recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested? ❑ Yes ❑ No

    If yes, indicate the facility and month and year of discharge in the space provided.

    Facility Name _____ ___ ___ / ___ ___ ___ ___ (Month / Year)

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

Continued

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

25. NPI

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

27. Place of Service

28. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTICOAGULANTS, ORAL COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral form, F-00806. Pharmacy providers are required to use the PA/PDL for Anticoagulants, Oral 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

   ForwardHealth
   Prior Authorization
   Ste 88
   313 Blettner Blvd
   Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Anticoagulants, Oral form.

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

Element 14
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Pradaxa®. If yes is checked, list the dates Pradaxa® was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 15
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Pradaxa®. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Xarelto®. If yes is checked, list the dates Xarelto® was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 17
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Xarelto®. If yes is checked, list the drug(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.

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 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 4
Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral

(A copy of the "Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTICOAGULANTS, ORAL

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral Completion Instructions, F-00806A. 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 Anticoagulants, Oral 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, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

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

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Pradaxa®? ❑ Yes ❑ No

If yes, list the dates Pradaxa® was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and Pradaxa®? ❑ Yes ❑ No

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

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Xarelto®? ❑ Yes ❑ No

    If yes, list the dates Xarelto® was taken. _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

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

    If yes, list the drug(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 and / 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 be included here.

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTIEMETICS, CANNABINOIDS 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 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 items. 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 Antiemetics, Cannabinoids, F-00194. Pharmacy providers are required to use the PA/PDL for Antiemetics, Cannabinoids 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

For PA requests for dronabinol, providers are required to complete Section III and either Section III A or Sections III B and III C of the PA/PDL for Antiemetics, Cannabinoids form.

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 diagnosis description.

SECTION III A — CLINICAL INFORMATION FOR MARINOL® ONLY FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA

Element 13
Check the appropriate box to indicate whether or not the member is experiencing weight loss or cachexia caused by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).

Element 14
Enter the member's current height in inches.

Element 15
Enter the member's current weight in pounds and the month, day, and year the member's weight was taken in the space provided.

Element 16
Enter the member's body mass index (BMI). The calculation for BMI is indicated.

Element 17
List the details about the actions used to increase the member's dietary intake.

Element 18
List the details about the member's current dietary plan, including daily caloric intake.

Element 19
Indicate the member's normal baseline weight in pounds.

Element 20
Check the appropriate box to indicate whether or not the member is currently taking Marinol®. If yes is checked, list the date Marinol® was started, the daily dose, and the member's weight prior to starting Marinol® treatment.

SECTION III B — CLINICAL INFORMATION FOR MARINOL® AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA AND VOMITING

Element 21
Check the appropriate box to indicate whether or not the member is experiencing chemotherapy-related nausea and vomiting.

Element 22
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with ondansetron. If yes is checked, list the date ondansetron was taken and describe the clinically significant adverse drug reaction in the space provided.

Element 23
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug(s) the member is taking and ondansetron. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 24
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of ondansetron. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using ondansetron in the space provided.

Element 25
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with Emend®. If yes is checked, list the dates Emend® was taken and describe the clinically significant adverse drug reaction in the space provided.

Element 26
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug(s) the member is taking and Emend®. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 27
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of Emend®. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using Emend® in the space provided.

SECTION III C — ADDITIONAL CLINICAL INFORMATION FOR DRONABINOL REQUESTS
Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol®.

Element 28
Provide detailed clinical information why the member cannot use Marinol® and why it is medically necessary that the member receive dronabinol instead of Marinol® in the space provided.

SECTION IV — 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 V — ADDITIONAL INFORMATION

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

ATTACHMENT 6
Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids

(A copy of the "Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTIEMETICS, CANNABINOIDS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids Completion Instructions, F-00194A. 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 Antiemetics, Cannabinoids form signed by the prescriber before submitting a PA request on the Portal, by fax, or by mail. 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 PA requests for dronabinol, providers are required to complete Section III and either Section III A or Sections III B and III C of this form.)

12. Diagnosis Code and Description

SECTION III A — CLINICAL INFORMATION FOR MARINOL® FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA

13. Is the member experiencing weight loss or cachexia caused by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ❑ Yes ❑ No

14. Current Height — Member (In Inches)	15. Current Weight — Member (In Pounds) Weight _____(lbs) Date Taken ____ ____ / ____ ____ / ____ ____ ____ ____ Month Day Year
16. Body Mass Index (BMI) — Member (lb/in^2)	$\underline{\text{BMI = 703 X (Weight in Pounds)}}$ $(\text{Height in Inches})^2$

17. List the details about the actions used to increase the member's dietary intake.

Continued

SECTION III A — CLINICAL INFORMATION FOR MARINOL® FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA (Continued)

18. List the details about the member's current dietary plan, including daily caloric intake.

19. Indicate the member's normal baseline weight (in pounds).

20. Is the member currently taking Marinol®? ❑ Yes ❑ No

If yes, list the date Marinol® was started. _____

List the daily dose of Marinol®. _____

List the member's weight (in pounds) prior to starting Marinol® treatment. _____

SECTION III B — CLINICAL INFORMATION FOR MARINOL® AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA AND VOMITING

21. Is the member experiencing chemotherapy-related nausea and vomiting? ❑ Yes ❑ No

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

If yes, list the dates ondansetron was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

23. Is there a clinically significant drug interaction between another drug(s) the member is taking and ondansetron? ❑ Yes ❑ No

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

24. Does the member have a medical condition(s) that prevents the use of ondansetron? ❑ Yes ❑ No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using ondansetron in the space provided.

Continued

SECTION III B — CLINICAL INFORMATION FOR MARINOL® AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA AND VOMITING (Continued)

25. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Emend®? ❑ Yes ❑ No

If yes, list the dates Emend® was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

26. Is there a clinically significant drug interaction between another drug(s) the member is taking and Emend®? ❑ Yes ❑ No

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

27. Does the member have a medical condition(s) that prevents the use of Emend®? ❑ Yes ❑ No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using Emend® in the space provided.

SECTION III C — ADDITIONAL CLINICAL INFORMATION FOR DRONABINOL REQUESTS (Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol®.)

28. Provide detailed clinical information why the member cannot use Marinol® and why it is medically necessary that the member receive dronabinol instead of Marinol®.

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 7
Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions

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

FORWARDHEALTH

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

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents, F-00281. Pharmacy providers are required to use the PA/PDL for Fentanyl Mucosal Agents form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

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

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

Element 14
Check the appropriate box to indicate whether or not the member has cancer that is causing persistent pain.

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

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

Element 17
Check the appropriate box to indicate whether or not the member has experienced breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs. If yes is checked, list the short-acting analgesic drug(s) and dose(s) the member has previously 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.

Note: ForwardHealth will not approve a days' supply greater than 183 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 STAT-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 8
Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions, F-00281A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents 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, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Does the member have cancer that is causing persistent pain? ❑ Yes ❑ No

15. Is the member tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain? ❑ Yes ❑ No

16. Is the member currently taking a long-acting opioid analgesic drug(s)? ❑ Yes ❑ No

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

Drug Name _____ Daily Dose _____

Drug Name _____ Daily Dose _____

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

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

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

Drug Name _____ Daily Dose _____

Drug Name _____ Daily Dose _____

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 183 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 and / 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 be included here.

ATTACHMENT 9
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions

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

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FORWARDHEALTH

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

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents, F-00238, to request PA for GLP-1 agents. Pharmacy providers are required to use the PA/PDL for GLP-1 Agents form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL GLP-1 Agents form.

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

Element 14
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the member is currently receiving long-acting insulin injections (e.g., Lantus, Levemir®.

Element 16
Check the appropriate box to indicate whether or not the member is currently receiving rapid-acting or short-acting insulin injections.

Element 17
Check the appropriate box to indicate whether or not the member is currently receiving intermediate-acting or premixed insulin injections.

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

Element 19
Check the appropriate box to indicate whether or not the member currently has or is there a history of gastroparesis.

Element 20
Check the appropriate box to indicate whether or not the member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.

Element 21
Indicate the member's most current hemoglobin (HbA1c). In the STAT-PA system, indicate the member's most current HbA1c as a three-digit number (e.g., if the member's most current HbA1c is 5.6 percent, enter "056").

Element 22
Indicate the date the member's most current HbA1c was measured in MM/DD/CCYY format. The member's most current HbA1c measurement must be within the past six months.

Element 23
Check the appropriate box to indicate whether or not the member has been taking the maximum dose of metformin (1,700 mg/day to 2,500 mg/day) for the past three months.

Element 24
Check the appropriate box to indicate whether or not the member is currently taking and will continue to take the maximum effective dose of metformin.

Element 25
Check the appropriate box to indicate whether or not the member is unable to take the maximum effective dose of metformin. If yes is checked, list the reason(s) why the member is not taking the maximum effective dose of metformin in the space provided.

Element 26
Check the appropriate box to indicate whether or not the member has been taking the maximum effective dose of a sulfonylurea for the past three months.

Element 27
Check the appropriate box to indicate whether or not the member is currently taking and will continue to take the maximum effective dose of a sulfonylurea. If yes is checked, list the drug name, dose, and directions for use in the space provided.

Element 28
Check the appropriate box to indicate whether or not the member is unable to take the maximum effective dose of a sulfonylurea. If yes is checked, list the reason(s) why the member is not taking the maximum effective dose of a sulfonylurea in the space provided.

Element 29
Check the appropriate box to indicate whether or not the member is currently using a GLP-1 agent. If yes is checked, complete Section IIIA of the PA/PDL for GLP-1 Agents form.

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

Element 30
Check the appropriate box to indicate whether or not the member has been using a GLP-1 agent for the past six months.

Element 31
Check the appropriate box to indicate whether or not the member's most current HbA1c has decreased by at least 0.5 percent since starting a GLP-1 agent.

Element 32
Check the appropriate box to indicate whether or not the member's HbA1c has dropped below seven percent since starting a GLP-1 agent.

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

Element 33
Check the appropriate box to indicate whether or not the member has taken the maximum dose of Byetta for at least three consecutive months in the last year and failed to achieve at least a 0.5 percent decrease in HbA1c. If yes is checked, list the dates Byetta was taken, the dose of Byetta, and directions for use. In addition, list the member's HbA1c values prior to starting Byetta, the member's HbA1C values during treatment with Byetta, and the dates the values were measured in the space provided.

Element 34
Check the appropriate box to indicate whether or not the member has taken Byetta in the last year and experienced a clinically significant adverse drug reaction. If yes is checked, list the dates Byetta was taken, the dose of Byetta, directions for use, and specific details about the clinically significant adverse drug reaction in the space provided.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 35 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 36 — Days' Supply Requested
Enter the requested days' supply.

Element 37 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider taxonomy code is not 333600000X.

Element 38 — 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 39 — 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 40 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 41 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 42 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 43 — 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 44 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 45 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 46
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 10
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents

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

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00238 (07/13)

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions, F-00238A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

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

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Is the member 18 years of age or older?	❑ Yes	❑ No
15. Is the member currently receiving long-acting insulin injections (e.g., Lantus, Levemir®)?	❑ Yes	❑ No
16. Is the member currently receiving rapid-acting or short-acting insulin injections?	❑ Yes	❑ No
17. Is the member currently receiving intermediate-acting or premixed insulin injections?	❑ Yes	❑ No
18. Does the member currently have or is there a history of pancreatitis?	❑ Yes	❑ No
19. Does the member currently have or is there a history of gastroparesis?	❑ Yes	❑ No
20. Is the member participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

21. Indicate the member's most current hemoglobin (HbA1c).	22. Date Member's HbA1c Measured (Within the Past Six Months)
_____ _____. _____ %	_____ _____ / _____ _____ / _____ _____ _____ _____ Month Date Year

23. Has the member been taking the maximum effective dose of metformin (1,700 mg / day to 2,500 mg / day) for the past three months?	❑ Yes	❑ No
24. Is the member currently taking and will continue to take the maximum effective dose of metformin?	❑ Yes	❑ No
25. Is the member unable to take the maximum effective dose of metformin?	❑ Yes	❑ No

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

26. Has the member been taking the maximum effective dose of a sulfonylurea for the past three months?	❑ Yes	❑ No
27. Is the member currently taking and will continue to take the maximum effective dose of a sulfonylurea?	❑ Yes	❑ No

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

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

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

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

If yes, complete Section IIIA of this form.

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

30. Has the member been using a GLP-1 agent for the past six months?	❑ Yes	❑ No
31. Since starting a GLP-1 agent, has the member's most current HbA1c decreased by at least 0.5 percent?	❑ Yes	❑ No
32. Since starting a GLP-1 agent, has the member's HbA1c dropped below seven percent?	❑ Yes	❑ No

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

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

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

Continued

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

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

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

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

35. National Drug Code (11 Digits)	36. Days' Supply Requested (Up to 365 Days)

37. NPI

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

39. Place of Service

40. Assigned PA Number

41. Grant Date	42. Expiration Date	43. Number of Days Approved

SECTION V — AUTHORIZED SIGNATURE

44. **SIGNATURE** — Prescriber	45. Date Signed

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 11
Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Completion Instructions" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, OMEGA-3 ACIDS 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.

Prior authorization requests for Lipotropics, Omega 3 Acids submitted by fax or by mail require the use of this form. 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 Lipotropics, Omega 3 Acids form, F-00162, to request PA for Lipotropics, Omega 3 Acids. 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 PA requests submitted by fax, prescribers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment to ForwardHealth at (608) 221-8616.

3) For PA requests submitted 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 prescribing provider.

Element 5 — National Provider Identifier (NPI) — Prescriber
Enter the prescribing provider's National Provider Identifier (NPI).

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 billing provider's NPI.

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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL Lipotropics, Omega-3 Acids form.

Element 15 — Diagnosis Code and Description
Enter the most specific *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
Check the appropriate box to indicate whether or not the member has an allergy or sensitivity to fish.

Element 17
Check the appropriate box to indicate whether or not the member's triglyceride level has been 500 mg/dL or greater in the past five years. If yes is checked, list the triglyceride level and test date in the space provided.

Element 18
Enter the member's most recent lipid panel, including the date the panel was taken, total cholesterol, high-density lipoprotein (HDL) cholesterol, low-density lipoprotein (LDL) cholesterol, and triglyceride levels in the space provided.

Element 19
Enter the member's current lipid- and triglyceride-lowering therapy, including all drug names, daily doses, and start dates in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR MEMBERS CURRENTLY TAKING AN OMEGA-3 ACID

Element 20
Check the appropriate box to indicate whether or not the member's triglyceride level decreased by 20 percent or more from baseline. If yes is checked, list test date and triglyceride level in the space provided.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED OMEGA-3 ACID REQUESTS ONLY

Element 21
Check the appropriate box to indicate whether or not, in the last year, the member has taken the maximum dose of Lovaza® for at least **four** consecutive months and failed to achieve at least a 30 percent decrease in triglyceride level from baseline. If yes is checked, list the date Lovaza® was taken and the daily dose, the member's baseline triglyceride level prior to starting Lovaza® and the date the test was taken, and the member's triglyceride levels during treatment with Lovaza® and the test dates in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

Element 23 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 24
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 12
Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids

(A copy of the "Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00162 (07/13)

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 LIPOTROPICS, OMEGA-3 ACIDS

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Completion Instructions, F-00162A, for more information. 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.

Providers may call the Drug Authorization and Policy Override Center 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 (Required for all PA requests.)

15. Diagnosis Code and Description

16. Does the member have an allergy or sensitivity to fish? ❑ Yes ❑ No

17. Has the member's triglyceride level been measured at 500 mg/dL or greater? ❑ Yes ❑ No

If yes, list the member's highest triglyceride level and the test date.

Triglyceride Level _____ Test Date _____

18. List the member's most recent lipid panel and date taken. (Date must be within the past three months.)

Date of Lipid Panel _____

Total Cholesterol _____

High-Density Lipoprotein (HDL) Cholesterol _____

Low-Density Lipoprotein (LDL) Cholesterol _____

Triglyceride _____

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

19. List the member's current lipid- and triglyceride-lowering therapy.

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR MEMBERS CURRENTLY TAKING AN OMEGA-3 ACID

20. Has the member's triglyceride level decreased by 20 percent or more from baseline? ❑ Yes ❑ No

If yes, list the member's baseline triglyceride level prior to starting an Omega-3 Acid and the date the test was taken.

Triglyceride Level _____ Test Date _____

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED OMEGA-3 ACID REQUESTS ONLY

21. In the last year, has the member taken the maximum dose of Lovaza® for at least **four** consecutive months and failed to achieve at least a 30 percent decrease in triglyceride level from baseline? ❑ Yes ❑ No

If yes, list the dates Lovaza® was taken for the Lovaza® trial. _____

List the daily dose of Lovaza®. _____

List the member's baseline triglyceride level prior to starting Lovaza® and the date taken.

Triglyceride Level _____ Test Date _____

List the member's triglyceride levels during treatment with Lovaza® and test date.

Triglyceride Level _____ Test Date _____

Triglyceride Level _____ Test Date _____

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 13
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other Completion Instructions

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

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FORWARDHEALTH

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

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other, F-00280. Pharmacy providers are required to use the PA/PDL for Migraine Agents, Other form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

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

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

Element 14
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least three preferred drugs from the Migraine Agents, Other drug class. If yes is checked, list each of the three preferred drugs the member has taken from the Migraine Agents, Other drug class including the dates the drugs were taken. Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 15 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 16 — 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 17 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 18 — Days' Supply Requested
Enter the requested days' supply.

Element 19 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 20 — 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 21 — 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 22 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 23 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 24 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 25 — Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 26
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 14
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other Completion Instructions, F-00280A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

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

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least **three** preferred drugs from the Migraine Agents, Other drug class? ❑ Yes ❑ No

If yes, list the drug name and dates the drug was taken in the space provided for **each** of the **three** preferred drugs the member has taken from the Migraine Agents, Other drug class.

Drug Name _____ Dates Taken _____

Drug Name _____ Dates Taken _____

Drug Name _____ Dates Taken _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Continued

SECTION IV — AUTHORIZED SIGNATURE

15. **SIGNATURE** — Prescriber	16. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)	18. Days' Supply Requested (Up to 365 Days)

19. NPI

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

21. Place of Service

22. Assigned PA Number

23. Grant Date	24. Expiration Date	25. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 15
Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators Completion Instructions

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

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FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MULTIPLE SCLEROSIS (MS) AGENTS, IMMUNOMODULATORS COMPLETION INSTRUCTIONS

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

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

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

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

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators form, F-00805. Pharmacy providers are required to use the PA/PDL for MS Agents, Immunomodulators 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, by fax, or by mail. 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 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 PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Ms Agents, Immunomodulators form.

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

Element 14
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the following preferred MS interferons: Avonex, Betaseron, or Rebif. If yes is checked, list the MS interferon(s) used, the dates the preferred MS interferon(s) was taken and describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction in the space provided.

Element 15
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and at least one of the following preferred MS interferons: Avonex, Betaseron, or Rebif. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of at least one of the following preferred MS interferons: Avonex, Betaseron, or Rebif. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred MS interferons in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Copaxone. If yes is checked, list the dates Copaxone was taken and describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction in the space provided.

Element 18
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Copaxone. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 19
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of Copaxone. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using Copaxone in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

Element 21 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

Element 24 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 25 — Date of Service
Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

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

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

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

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

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

Element 30 — Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 16
Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis Agents, Immunomodulators

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MULTIPLE SCLEROSIS (MS) AGENTS, IMMUNOMODULATORS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators Completion Instructions, F-00805A. 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 Multiple Sclerosis (MS) Agents, Immunomodulators 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, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the following preferred MS interferons: Avonex, Betaseron, or Rebif? ❑ Yes ❑ No

If yes, list the preferred MS interferon(s) used. _____

List the dates the preferred MS interferon(s) was taken. _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and at least one of the following preferred MS interferons: Avonex, Betaseron, or Rebif? ❑ Yes ❑ No

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

16. Does the member have a medical condition(s) that prevents the use of at least one of the preferred MS interferons: Avonex, Betaseron, or Rebif? ❑ Yes ❑ No

    If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred MS interferons in the space provided.

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

    If yes, list the dates Copaxone was taken. _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

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

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

19. Does the member have a medical condition(s) that prevents the use of Copaxone? ❑ Yes ❑ No

    If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using Copaxone in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

Continued

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

24. NPI

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

26. Place of Service

27. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

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

ATTACHMENT 17
Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents Completion Instructions

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR OPIOID DEPENDENCY 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 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/Preferred Drug List (PA/PDL) for Opioid Dependency Agents, F-00081. Pharmacy providers are required to use the PA/PDL for Opioid Dependency 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted 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).

Note: For members enrolled in the BadgerCare Plus Core Plan, PA requests for Suboxone® and buprenorphine must be submitted on the Portal or by fax or mail. For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, PA requests for Suboxone® and buprenorphine may be submitted using the STAT-PA system, the Portal, or by fax or mail.

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Check the name of drug prescribed.

Element 5 — Drug Strength
Check the strength(s) of drug in milligrams.

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL Opioid Dependency, Agents form.

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

Element 14
Check the appropriate box to indicate whether or not the member is 16 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the prescribing physician is a Drug Addiction Treatment Act (DATA 2000)-waived physician. If yes is checked, indicate the prescribing physician's "X" Drug Enforcement Administration (DEA) number in the space provided. Check no if the prescribing physician does not participate in this program.

Element 16
Check the appropriate box to indicate whether or not the member is taking any other opioids, tramadol, or carisoprodol. If yes is checked, list the drugs taken and the dates taken in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has any untreated or unstable psychiatric conditions that may interfere with compliance. If yes is checked, list the conditions in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member is pregnant or nursing.

SECTION IV — ATTESTATION

The physician is required to read and sign the attestation statement for consideration of the PA request.

Element 19
Check the appropriate box to indicate whether or not the prescribing physician has read the attestation statement.

Element 20
Check the appropriate box to indicate whether or not the prescribing physician agrees to follow the guidelines set forth by State Medical Boards for opioid addiction treatment.

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

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

SECTION V — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE TABLET REQUESTS
This section must be completed for pregnant or nursing women only.

Element 23
Check the appropriate box to indicate whether or not the member is pregnant.

Element 24
Check the appropriate box to indicate whether or not the member is nursing.

Element 25
Check the appropriate box to indicate whether or not the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant or nursing women.

Element 26
Check the appropriate box to indicate whether or not the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women.

SECTION VI — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE-NALOXONE TABLET REQUESTS
Prior authorization requests for buprenorphine-nalaxone tablets must include clinical justification for prescribing buprenorphine-naloxone tablets instead of Suboxone® film.

Element 27
Provide detailed clinical information why the member cannot use Suboxone® film and why it is medically necessary that the member receive buprenorphine-naloxone tablets instead of Suboxone® film in the space provided.

SECTION VII — AUTHORIZED SIGNATURE

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

Element 29 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VIII — FOR PHARMACY PROVIDERS USING STAT-PA

Element 30 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 31 — Days' Supply Requested
Enter the requested days' supply.

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

Element 32 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 33 — 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 34 — 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 35 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 36 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 37 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 38 — Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION IX — ADDITIONAL INFORMATION

Element 39
Include 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/Preferred Drug List (PA/PDL) for Opioid Dependency Agents

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

(This page was intentionally left blank.)

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents Completion Instructions, F-00081A. 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 Opioid Dependency 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, by fax, or by mail. 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 (Check One)
   - ❑ Suboxone® film
   - ❑ Buprenorphine tablet
   - ❑ Buprenorphine-naloxone tablet

5. Drug Strength (Check Strength[s])
   - Suboxone® film ❑ 2 mg ❑ 4 mg ❑ 8 mg ❑ 12 mg
   - Buprenorphine tablet ❑ 2 mg ❑ 8 mg
   - Buprenorphine-naloxone tablet ❑ 2 mg ❑ 8 mg

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Is the member 16 years of age or older? ❑ Yes ❑ No

15. Does the prescribing physician have a valid Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone® and buprenorphine for opioid dependence? ❑ Yes ❑ No

    If yes, enter the prescribing physician's "X" Drug Enforcement Administration (DEA) number in the space provided.

16. Is the member taking any other opioids, tramadol, or carisoprodol? ❑ Yes ❑ No

    If yes, list the drugs taken and the dates they were taken in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

17. Does the member have any untreated or unstable psychiatric conditions that may interfere with compliance? ❑ Yes ❑ No

If yes, list the conditions in the space provided.

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

SECTION IV — ATTESTATION

The U.S. Department of Health and Human Services endorses the Federation of State Medical Boards — Model Policy Guidelines for Opioid Addiction Treatment. The prescribing physician agrees to follow these guidelines, including:

- The patient should receive opioids from only one physician and/or pharmacy when possible.
- The physician should employ the use of a written agreement between the physician and patient addressing issues such as:
  - ✓ Alternative treatment options.
  - ✓ Regular toxicologic testing for drugs of abuse and therapeutic drug levels.
  - ✓ Number and frequency of all prescription refills.
  - ✓ Reasons for which drug therapy may be discontinued.
- Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as:
  - ✓ Absence of toxicity.
  - ✓ Absence of medical or behavioral adverse effects.
  - ✓ Responsible handling of medications.
  - ✓ Compliance with all elements of the treatment plan, including recovery-oriented activities, psychotherapy, and/or psychosocial modalities.
  - ✓ Abstinence from illicit drug use.

19. Has the prescribing physician read the attestation statement? ❑ Yes ❑ No

20. Does the prescribing physician agree to follow the guidelines set forth by State Medical Boards for opioid addiction treatment? ❑ Yes ❑ No

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

SECTION V — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE TABLET REQUESTS (Complete for pregnant or nursing women only.)

23. Is the member pregnant? ❑ Yes ❑ No

24. Is the member nursing? ❑ Yes ❑ No

25. Has the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant or nursing women? ❑ Yes ❑ No

26. Has the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women? ❑ Yes ❑ No

SECTION VI — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE-NALOXONE TABLET REQUESTS (Prior authorization requests for buprenorphine-naloxone tablets must include clinical justification for prescribing buprenorphine-naloxone tablets instead of Suboxone® film.)

27. Provide detailed clinical justification why the member cannot use Suboxone® film and why it is medically necessary that the member receive buprenorphine-naloxone tablets instead of Suboxone® film.

SECTION VII — AUTHORIZED SIGNATURE

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

Continued

SECTION VIII — FOR PHARMACY PROVIDERS USING STAT-PA

30. National Drug Code (11 Digits)	31. Days' Supply Requested (Up to 183 Days)

32. NPI

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

34. Place of Service

35. Assigned PA Number

36. Grant Date	37. Expiration Date	38. Number of Days Approved

SECTION IX — ADDITIONAL INFORMATION

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

ATTACHMENT 19
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets Completion Instructions

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

FORWARDHEALTH

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

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

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

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

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

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets, F-00433. Pharmacy providers are required to use the PA/PDL for PPI Orally Disintegrating Tablets 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PRESCRIPTION INFORMATION

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

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

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

Element 7 — Refills
Enter the number of refills.

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

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

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

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

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

SECTION III — CLINICAL INFORMATION

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for PPI Orally Disintegrating Tablets form.

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

Element 14
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of esomeprazole. If yes is checked, list the approximate date esomeprazole was taken and details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 15
Check the box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and esomeprazole. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 16
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of omeprazole. If yes is checked, list the approximate date omeprazole was taken and details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 17
Check the box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and omeprazole. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 18
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of pantoprazole. If yes is checked, list the approximate date pantoprazole was taken and details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided. If the member is under five years old, check the not applicable box.

Element 19
Check the box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and pantoprazole. If yes is checked, list the drug(s) and interaction(s) in the space provided. If the member is under five years old, check the not applicable box.

Element 20
Check the box to indicate whether or not the member has a medical condition(s) that prevents the use of PPI suspensions. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using PPI suspensions in the space provided.

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

SECTION IV — AUTHORIZED SIGNATURE

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

Element 23 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

Element 26 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

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

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

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

Element 32 — Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 33
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

ATTACHMENT 20
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets

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

FORWARDHEALTH

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

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets Completion Instructions, F-00433A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets 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, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

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

SECTION II — PRESCRIPTION INFORMATION

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

8. Directions for Use

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

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of esomeprazole? ❑ Yes ❑ No

If yes, list the dates esomeprazole was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and esomeprazole? ❑ Yes ❑ No

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

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of omeprazole? ❑ Yes ❑ No

    If yes, list the dates omeprazole was taken. _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

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

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

18. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of pantoprazole? (If the member is under 5 years old, check “N/A.") ❑ Yes ❑ No ❑ N/A

    If yes, list the dates pantoprazole was taken. _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

19. Is there a clinically significant drug interaction between another drug the member is taking and pantoprazole? (If the member is under 5 years old, check “N/A.") ❑ Yes ❑ No ❑ N/A

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

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

20. Does the member have a medical condition(s) that prevents the use of PPI suspensions? ❑ Yes ❑ No

    If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using PPI suspensions in the space provided.

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

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

26. NPI

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

28. Place of Service

29. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

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