

**Affected Programs:** BadgerCare Plus, Medicaid

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

## **Clarification for the Revised Prior Authorization/ Preferred Drug List (PA/PDL) Exemption Request Form and Completion Instructions**

This *ForwardHealth Update* provides clarification for the revised Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (09/13), form and completion instructions.

This *ForwardHealth Update* provides clarification for the revised Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, F-11075A (09/13), and Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, F-11075 (09/13), which ForwardHealth published in the July 2013 *Update* (2013-35), titled “July 2013 Preferred Drug List Review and Other Pharmacy Policy Changes.” Clinical criteria for the PA/PDL Exemption Request Form can be found in A Prescriber’s Responsibilities for Prior Authorization for Preferred Drug List Drugs topic (topic #10937) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook on the ForwardHealth Portal at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

### **Clarifications for Clinical Criteria for Non-preferred Drugs**

The information in this section applies to non-preferred PDL drugs.

### ***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.

### ***Alternate Clinical Criteria for Non-preferred Drugs in Eligible Drug Classes Only***

The following drug classes have alternate clinical criteria that may be considered if the member does not meet the clinical criteria for non-preferred drugs listed above:

- 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.

Alternate clinical criteria that may be considered if the member does not meet the clinical criteria for non-preferred drugs listed above 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.

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

ForwardHealth has revised the PA/PDL Exemption Request form to clarify the completion instructions. 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 September 1, 2013, must be submitted on the revised form or they will be returned.

### **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/](http://www.forwardhealth.wi.gov/).

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# **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.)

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## 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, pharmacy providers may access [www.forwardhealth.wi.gov/](http://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.

*Note:* If applicable, prescribers may also complete Section IV of the PA/PDL Exemption Request form if the non-preferred drug belongs to one of the following drug classes:

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

### 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 — ALTERNATE CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY (If applicable, prescribers may also complete this section.)**

**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” form is located on the following pages.)

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**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](http://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.

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**SECTION I — MEMBER INFORMATION**

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

2. Member Identification Number

3. Date of Birth — Member

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**SECTION II — PRESCRIPTION INFORMATION**

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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

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

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12. Diagnosis Code and Description

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

*Note:* If applicable, prescribers may also complete Section IV of this form if the non-preferred drug belongs to one of the following drug classes: Alzheimer's Agents; Anticonvulsants; Antidepressants, Other; Antidepressants, SSRI; Antiparkinson's Agents; Antipsychotics; HIV-AIDS; or Pulmonary Arterial Hypertension.

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).

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**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 — ALTERNATE CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY (If applicable, prescribers may also complete this section.)**

17. Indicate the drug class.

- |   |  |
|---|--|
| <input type="checkbox"/> Alzheimer's Agents     | <input type="checkbox"/> Antiparkinson's Agents          |
| <input type="checkbox"/> Anticonvulsants        | <input type="checkbox"/> Antipsychotics                  |
| <input type="checkbox"/> Antidepressants, Other | <input type="checkbox"/> HIV-AIDS                        |
| <input type="checkbox"/> Antidepressants, SSRI  | <input type="checkbox"/> 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*

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**SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA**

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23. National Drug Code (11 Digits)

24. Days' Supply Requested (Up to 365 Days)

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25. NPI

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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.)

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27. Place of Service

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28. Assigned PA Number

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29. Grant Date

30. Expiration Date

31. Number of Days Approved

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**SECTION VI — ADDITIONAL INFORMATION**

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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.

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