**September 19, 2013:** This *Update* has been revised since its original publication. Information on page 4 regarding PA requests for Anti-obesity drugs and information on pages 6 through 8 regarding a prescriber's handwritten signature on the PA/DGA form have been revised. Revisions are indicated in red.

ForwardHealth
Wisconsin serving you

**Update**
**September 2013**

**No. 2013-46**

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

# Changes to Pharmacy Policies Effective Fall 2013

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to pharmacy policies effective October 1, 2013, unless otherwise noted.

This *ForwardHealth Update* provides an overview of changes to pharmacy policy regarding the following:

- Anti-obesity drugs.
- Growth hormone drugs.
- The Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/13).
- Prospective Drug Utilization Review (DUR) — High Dose alerts.
- State Maximum Allowed Cost (MAC) drug pricing requests.
- Three-month supply drugs.

These policy changes are effective October 1, 2013, unless otherwise noted. Prior authorization forms have been revised, as well as the corresponding guidelines and clinical criteria, to reflect these pharmacy policy changes.

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* does not contain any coverage or policy changes for the Wisconsin AIDS/HIV Drug Assistance Program.

## Anti-obesity Drugs

ForwardHealth has revised the Prior Authorization Drug Attachment for Anti-Obesity Drugs, F-00163 (10/13), and criteria for coverage of anti-obesity drugs for the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members. Providers may refer to Attachments 1 and 2 of this *Update* for a copy of the revised completion instructions and form. Prior authorization requests processed on and after October 1, 2013, must be submitted on the revised form or they will be returned.

Anti-obesity drugs are not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Anti-obesity drugs are covered for dual eligibles enrolled in a Medicare Part D Prescription Drug Plan.

### *Clinical Criteria for Anti-obesity Drugs*

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

- The member has a body mass index (BMI) greater than or equal to 30.

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

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

- The member is 16 years of age or older. (*Note:* Members only need to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The prescriber has evaluated and determined that the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.
- For controlled substance anti-obesity drugs, the member does not have a medical history of substance abuse or misuse.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

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

*Note:* ForwardHealth does not cover the brand name (i.e., innovator) anti-obesity drug if a Food and Drug Administration -approved generic equivalent is available. ForwardHealth does not cover any brand name innovator phentermine products. In addition, ForwardHealth does not cover over-the-counter (OTC) anti-obesity drugs.

ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents and brand name phentermine products as noncovered services. Members do not have appeal rights for noncovered services.

### Clinical Criteria for Benzphetamine, Diethylpropion, Phendimetrazine, and Phentermine

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

If the member does not meet a weight loss goal of at least 10 pounds of his or her weight from baseline during the initial three-month approval or if the member has completed six months of continuous benzphetamine, diethylpropion, phendimetrazine, or phentermine treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug.

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

### Clinical Criteria for Belviq

If clinical criteria for anti-obesity drugs are met, initial PA requests for Belviq will be approved for up to a maximum of three months. If the member meets a weight loss goal of at least five percent of his or her weight from baseline during the first three months of treatment, PA may be requested for an additional six months of treatment. If the member's weight remains below baseline, subsequent PA renewal periods for Belviq are a maximum of six months.

Prior authorization requests for Belviq may be approved for a maximum treatment period of 24 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least five percent of his or her weight from baseline during the initial three-month approval, or if the member's weight does not remain below baseline, or if the member has completed 24 months of continuous Belviq treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug.

ForwardHealth allows only two weight loss attempts with Belviq during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

### Clinical Criteria for Qysmia

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

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

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

### Clinical Criteria for Xenical®

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

If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, or if the member's weight does not remain below baseline, or if the member has completed 24 months of continuous Xenical® treatment, the member must wait six months before PA can be requested for Xenical®.

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

### Submitting Prior Authorization Requests for Anti-obesity Drugs

Prior Authorization requests for anti-obesity drugs must be submitted using the Prior Authorization Drug Attachment for Anti-Obesity Drugs form and must be submitted by prescribers or their designees, **not** pharmacy providers.

Prior authorization requests for anti-obesity drugs 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.
- 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

*Note:* Prior authorization requests for anti-obesity drugs submitted by fax or mail will not be processed as 24-hour drug PA requests. If an immediate decision is needed for a PA request, providers should call the DAPO Center during the noted business hours. If prescribers choose not to use the DAPO Center, the prescriber is required to submit a Prior Authorization Request Form (PA/RF) along with the applicable PA drug attachment form with the additional medical documentation.

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

## Growth Hormone Drugs

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092 (10/13), and criteria for coverage of growth hormone drugs for Standard Plan, Medicaid, and SeniorCare members. Providers may refer to Attachments 3 and 4 for a copy of the completion instructions and form. Prior authorization requests processed on and after October 1, 2013, must be submitted on the revised form or they will be returned.

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

Growth hormone drugs are noncovered drugs for Benchmark Plan, Core Plan, and Basic Plan members.

ForwardHealth does not cover growth hormone drugs for the following members and conditions:

- Members with Idiopathic Short Stature, which is a growth failure or short stature not associated with growth hormone deficiency or disease state.
- Pediatric members with growth failure or short stature with closed epiphyses.
- Pediatric members being treated with growth hormone drugs who have growth failure or short stature with a growth rate less than two cm/year.
- Members showing noncompliance with their growth hormone therapy.

Prior authorization requests submitted for these conditions will be returned as noncovered services. Members do not have appeal rights for noncovered services.

### *Clinical Criteria for Serostim*

ForwardHealth covers Serostim for members with a diagnosis of Acquired Immune Deficiency Syndrome wasting disease or cachexia.

If clinical criteria for Serostim are met, initial PA requests for Serostim will be approved for up to a maximum of one year. Prior authorization requests for Serostim must be submitted on the PA/PDL for Growth Hormone Drugs and may be submitted to ForwardHealth using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system, on the Portal, by fax, or by mail.

### *Clinical Criteria for Zorbtive*

ForwardHealth covers Zorbtive for members with a diagnosis of short bowel syndrome with dependence on parenteral nutrition. Members are limited to a 28-day course of the drug to reduce dependence on parenteral nutrition.

Prior authorization requests for Zorbtive must be submitted on the PA/PDL for Growth Hormone Drugs and may be submitted to ForwardHealth using the STAT-PA system, on the Portal, by fax, or by mail.

## Clinical Criteria for Pediatric Covered Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Members with the following congenital conditions; Noonan's Syndrome, Prader Willi Syndrome, Short stature homeobox-containing gene (SHOX) deficiency or Turner Syndrome. The member must have growth failure or short stature associated with one of the above congenital conditions.
- Growth failure or short stature associated with chronic renal insufficiency in pre-transplant members. Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.
- Growth failure or short stature associated with growth hormone deficiency confirmed with growth hormone stimulation testing demonstrating a growth hormone response of less than 10ng/mL:
  - ✓ Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.
  - ✓ Providers should indicate the type of stimulation test performed, month and year the test was done, and the results of the test. Stimulation testing should be conducted after an overnight fast, using a well standardized protocol. Additional required information to be submitted includes a copy of the entire testing procedure, including at a minimum: medical office notes, growth hormone levels from each blood sample taken, complete test results, and provider interpretation of results.
- Members born small for gestational age who are 2 years of age or older with a height that remains two standard deviations below the mean for chronological age. Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.
- Hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies. Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.

*Note:* All growth hormone prescriptions must be written by an endocrinologist or through an endocrinology consultation.

All of the pediatric covered indications that require the submission of detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment should include the following documentation at a minimum:

- Bone age results.
- Growth charts (including growth rate, growth percentiles, and Z-scores).
- Growth plate results.
- Image results.
- Lab testing.
- Medical office notes.

## Clinical Criteria for Adult Covered Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Growth Hormone Deficiency confirmed with an appropriate growth hormone stimulation test:
  - ✓ Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment including, but not limited to, image results, lab testing, and medical office notes.
  - ✓ Providers should indicate the type of stimulation test performed, month and year the test was done, and the results of the test. Stimulation testing should be conducted after an overnight fast, using a well standardized protocol. Additional required information to be submitted includes a copy of the entire testing procedure, including at a minimum: medical office notes, growth hormone levels from each blood sample taken, complete test results, and provider interpretation of results.

- Hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies. Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment including, but not limited to, image results, lab testing, and medical office notes.

*Note:* All growth hormone prescriptions must be written by an endocrinologist or through an endocrinology consultation.

### *Submitting Prior Authorization Requests for Growth Hormone Drugs*

If clinical criteria for growth hormone drugs are met, initial PA requests may be approved for up to a maximum of six months. Renewal requests may be approved for up to one year. Prior authorization requests must be submitted on the PA/PDL for Growth Hormone Drugs form and may be submitted to ForwardHealth using the Portal, by fax, or by mail. Prior authorization requests for the congenital conditions listed above may also be submitted through the STAT-PA system.

## Prior Authorization/Drug Attachment (PA/DGA)

ForwardHealth has revised the PA/DGA, to reflect how clinical information should be submitted for drug requests. Providers may refer to Attachments 5 and 6 for a copy of the completion instructions and form. Prior authorization requests processed on and after October 1, 2013, must be submitted on the revised form or they will be returned.

Individual sections have been established for specific types of drug requests and ForwardHealth has defined criteria for those sections. When completing the PA/DGA form, prescribers should complete the most appropriate section as it pertains to the drug being requested. The specific sections are as follows:

- HealthCheck "Other Services" drug requests.
- Diagnosis-restricted drug requests.
- Drugs with specific PA criteria addressed in the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.
- Other drug requests.

Prescribers are required to fill out the appropriate section(s), then provide a handwritten signature and date on the PA/DGA form. Once completed, the prescriber should send the PA/DGA form to the pharmacy. The pharmacy should complete a Prior Authorization Request Form (PA/RF), F-11018 (05/13), and submit it to ForwardHealth, along with the PA/DGA from the prescriber.

### *Clinical Information for HealthCheck "Other Services" Drug Requests*

If the prescriber writes a prescription for a drug that is not covered under the member's ForwardHealth benefit plan, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested through a HealthCheck "Other Services" PA request. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized are required. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request. This information should be documented on the PA/DGA in Section IV (Clinical Information for HealthCheck "Other Services" Drug Requests).

When completing the PA/DGA, prescribers should provide the diagnosis code and description, complete Section IV, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should not submit PA forms to ForwardHealth.

As a reminder, prescribers and pharmacy providers are required to retain a completed copy of the PA form(s).

*Note*: All HealthCheck "Other Services" drug PA requests must also include the date of the member's most recent HealthCheck screen, along with the name of the HealthCheck screener (who is required to be Medicaid-enrolled). HealthCheck "Other Services" is limited to members under 21 years of age.

### Clinical Information for Diagnosis-Restricted Drug Requests

If the prescriber writes a prescription with a diagnosis outside the ForwardHealth-allowed diagnoses for a drug, the prescriber is required to submit peer-reviewed medical literature to support the proven efficacy and safety of the requested use of the drug. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized are required. Medical records should be provided as necessary to support the PA request. This information should be documented on the PA/DGA in Section V (Clinical Information for Diagnosis-Restricted Drug Requests).

When completing the PA/DGA, prescribers should provide the diagnosis code and description, complete Section V, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should not submit PA forms to ForwardHealth.

As a reminder, prescribers and pharmacy providers are required to retain a completed copy of the PA form(s).

### Clinical Information for Drugs with Specific Prior Authorization Criteria Addressed in the Online Handbook

If a prescriber writes a prescription for one of the following drugs, a PA request is required to be submitted on the PA/DGA form:

- Ampyra.
- Cayston.
- Kalydeco.
- Namenda (members 44 years of age and younger).
- Stribild.
- Tobi Podhaler.
- Xeljanz.
- Xyrem.

Prescribers should refer to the Online Handbook for clinical criteria for each of the drugs listed above. This information should be documented on the PA/DGA in Section VI) Clinical Information for Drugs with Specific PA Criteria Addressed in the Online Handbook).

When completing the PA/DGA, prescribers should provide the diagnosis code and description, complete Section VI, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should not submit PA forms to ForwardHealth.

As a reminder, prescribers and pharmacy providers are required to retain a completed copy of the PA form(s).

### Clinical Information for Other Drug Requests

If the prescriber writes a prescription for a drug that requires the use of the PA/DGA form but that has not been previously referenced in this *Update*, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized are required. In addition, if the drug requested is a non-preferred PDL drug, prescribers are required to specifically address why other preferred PDL drugs cannot be utilized. Medical records and peer-reviewed medical

literature should be provided as necessary to support the PA request. This information should be documented on the PA/DGA in Section VII (Clinical Information for Other Drug Requests).

When completing the PA/DGA, prescribers should provide the diagnosis code and description, complete Section VII, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should not submit PA forms to ForwardHealth.

As a reminder, prescribers and pharmacy providers are required to retain a completed copy of the PA form(s).

*Note:* For assistance in identifying PDL drugs that require completion of Sections VI and VII of the PA/DGA form, prescribers may refer to the Preferred Drug List Quick Reference located on the Pharmacy Resources page of the Providers area of the Portal.

## Prospective Drug Utilization Review — High Dose

Effective for dates of process on and after September 14, 2013, the High Dose (HD) prospective DUR alert is an informational alert only. Pharmacies receive an informational message regarding all major HD alerts monitored by First Databank. The HD informational alerts do not require a response. This change was generated as a result of analysis and recommendations made to the DUR Board by Department of Health Services' staff. The data from the informational alerts are being collected over a period of time for further analysis by the DUR Board.

For more information about prospective DUR alerts, providers may refer to the Prospective Drug Utilization Review System topic (topic #1977) in the Drug Utilization Review chapter of the Claims section of the Online Handbook.

## State Maximum Allowed Cost Drug Pricing Review Request

ForwardHealth has revised the State Maximum Allowed Cost Drug Pricing Review Request, F-00030 (10/13), and established criteria for the use of the revised form. Providers may refer to Attachments 7 and 8 for a copy of the completion instructions and form. State MAC drug pricing requests processed on and after October 1, 2013, must be submitted on the revised form or they will be returned.

To request a review of state MAC pricing, pharmacy providers are required to complete, sign, and submit the State Maximum Allowed Cost Drug Pricing Review Request form certifying that the price listed is the actual net cost of the drug after rebates or discounts from a wholesaler or supplier. The pharmacy must also submit an invoice having a product date of purchase within 60 days of submitting the request. The invoice must include the following:

- Date of purchase.
- Purchased price.
- Purchaser.
- Product National Drug Code (NDC). If the NDC is not indicated on the invoice, the provider is required to handwrite the NDC on the invoice.
- Wholesaler/supplier name.

Requests for pricing review will not be accepted for Wholesale Acquisition Cost and expanded MAC rates on file for an NDC.

The State Maximum Allowed Cost Drug Pricing Review Request form and the supporting documentation must be submitted to the DAPO Center via fax at (608) 250-0246 or by mail to the following address:

ForwardHealth
Drug Authorization and Policy Override Center
313 Blettner Blvd

Madison WI 53784

Any action taken by ForwardHealth will be reflected in the state MAC data table.

## Drugs with a Three-Month Supply Maximum

ForwardHealth has revised the Three-Month Supply Drugs list.

For three-month supply drugs, the following apply:

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs are allowed to be dispensed in a three-month supply.

Dispensing a three-month supply of drugs streamlines the prescription-filling process for pharmacy providers, encourages the use of generic maintenance drugs when medically appropriate for a member, and results in savings to ForwardHealth programs.

### *Drugs Required to Be Dispensed in a Three-Month Supply*

ForwardHealth has revised the list of drugs for which pharmacy providers will be required to dispense a three-month supply. The revised Three-Month Supply Drugs list is available on the Pharmacy Resources page of the Providers area of the Portal. The list may be revised at any time, so providers should refer to the Pharmacy Resources page of the Portal for the most current list.

As a reminder, claims for drugs that are dispensed in less than a three-month supply but that are required to be dispensed in a three-month supply will be denied, and the following information will be provided:

- An Explanation of Benefits code stating "Three Month Supply Opportunity. A policy override must be granted by the Drug Authorization and Policy Override (DAPO) Center to dispense less than a three-month supply."
- A National Council for Prescription Drug Programs reject code.

### *Additional Drugs Allowed to Be Dispensed in a Three-Month Supply*

For drugs that are allowed to be dispensed in a three-month supply but are not required to be, pharmacy providers are encouraged to work with the member and the prescriber to determine whether or not it is clinically appropriate to dispense a three-month supply. Claims for these drugs will no longer be denied, as policy regarding the prospective DUR alert for insufficient quantity ("NS") is changing to make it an informational claim message. Providers will receive the informational claim message "Three Month Supply Opportunity" on claims for these drugs.

Refer to the Drugs with a Three-Month Supply Maximum topic (topic #1939) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Online Handbook for more information.

## Prescribing/Referring/Ordering Providers Are Required to Be Medicaid-Enrolled

As a reminder, as a result of the Affordable Care Act (ACA), all physicians and other professionals who prescribe, refer, or order services for Medicaid or BadgerCare Plus members on and after July 15, 2013, are required to be Medicaid-enrolled. Prior authorization requests received on and after July 15, 2013, and claims with dates of service on and after July 15, 2013, for services that are prescribed, referred, or ordered will be returned or denied, respectively, if they do not include the name and National Provider Identifier (NPI) of a Medicaid-enrolled provider. For more information on the enrollment options and new requirements for prescribing/referring/ordering providers, refer to the June 2013 *Update* (2013-34), titled "New Requirements for Prescribing/Referring/Ordering Providers Due to the Affordable Care Act," and to the August 2013 *Update* (2013-40), titled "Policy Clarification for Services That Are Prescribed, Referred, or Ordered."

### *Prior Authorization Forms Revised to Reflect New Requirements*

ForwardHealth has revised the Prior Authorization Drug Attachment for Anti-obesity Drugs Completion Instructions, the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Completion Instructions, F-00162A (10/13), and the Prior Authorization Drug Attachment for Synagis® Completion Instructions, F-00142A (10/13), to reflect the new requirements. Providers may refer to Attachments 1, 9, and 10 for a copy of the completion instructions.

## 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 09/19/2013 and information contained in this *Update* was incorporated into the Online Handbook on 09/23/2013.

# ATTACHMENT 1
# Prior Authorization Drug Attachment for Anti-obesity Drugs Completion Instructions

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

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**FORWARDHEALTH**

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

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

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

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

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

## INSTRUCTIONS

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

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

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

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

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

4) For 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 prescriber.

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

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

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

**Element 8 — Name — Billing Provider**
Enter the name of the billing provider. Prescribers should indicate their name and NPI as the billing provider on the PA request.

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

## SECTION II — PRESCRIPTION INFORMATION

**Element 10 — Drug Name**
Enter the drug name.

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

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

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

**Element 14 — Refills**
Enter the number of refills.

## SECTION III — CLINICAL INFORMATION

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

**Element 15 — Diagnosis Code and Description**
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

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

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

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

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

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

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

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

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

## SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

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

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

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

**Element 23**
Check the appropriate box to indicate whether or not the prescriber has evaluated and determined the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.

**Element 24**
Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse.

## SECTION IIIB — INITIAL COVERAGE REQUIREMENTS

Complete this section for initial requests for anti-obesity drugs.

**Element 25 — BMI Requirements**
Check the appropriate box to indicate whether or not the member's BMI is greater than or equal to 30 or greater than or equal to 27 but less than 30 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, or type II diabetes mellitus. If applicable, indicate the member's current risk factors.

**Element 26**
Check the appropriate box to indicate whether or not the member has participated in a weight loss treatment plan in the past six months and if the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan in the space provided.

## SECTION IV — AUTHORIZED SIGNATURE

**Element 27 — Signature — Prescriber**
The prescriber is required to complete and sign this form.

**Element 28 — Date Signed — Prescriber**
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

## SECTION V — ADDITIONAL INFORMATION

**Element 29**
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

# ATTACHMENT 2
# Prior Authorization Drug Attachment for Anti-obesity Drugs

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

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-00163 (10/13)

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

**FORWARDHEALTH**

# PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

**Instructions:** Type or print clearly. Before completing this form, read Prior Authorization Drug Attachment for Anti-obesity Drugs Completion Instructions, F-00163A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

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

15. Diagnosis Code and Description

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

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

## SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

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

*Continued*

**SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS (Continued)**

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

23. Has the prescriber evaluated and determined the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested? ❑ Yes ❑ No

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

**SECTION IIIB — INITIAL COVERAGE REQUIREMENTS**

25. BMI Requirements (Check A or B.)
   A. ❑ The member's BMI is greater than or equal to 30.
   B. ❑ The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors. Check the member's current risk factors.
      - ❑ Coronary Heart Disease.
      - ❑ Dyslipidemia.
      - ❑ Hypertension.
      - ❑ Sleep Apnea.
      - ❑ Type II Diabetes Mellitus.

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

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

**SECTION IV — AUTHORIZED SIGNATURE**

| 27. **SIGNATURE** — Prescriber | 28. Date Signed — Prescriber |
|---|---|
| | |

**SECTION V — ADDITIONAL INFORMATION**

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

# ATTACHMENT 3
# Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions" is located on the following pages.)

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**FORWARDHEALTH**

# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS COMPLETION INSTRUCTIONS

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

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

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

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

## INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092. Pharmacy providers are required to use the PA/PDL for Growth Hormone Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Pharmacy 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/.*

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 the 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 Growth Hormone Drugs 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.

## SECTIONS IIIA, IIIB, and IIIC

Complete the appropriate section of this form:

- Prior authorization requests for growth hormone drugs (except Serostim or Zorbtive): complete Section IIIA only.
- Prior authorization requests for Serostim: complete Section IIIB only.
- Prior authorization requests for Zorbtive: complete Section IIIC only.

## SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (EXCEPT SEROSTIM OR ZORBTIVE)

**Element 14**
Check the box to indicate whether or not the drug requested is a preferred growth hormone drug. If the drug is a non-preferred growth hormone drug, describe the reason for the request in the space provided.

**Element 15**
Check the box to indicate whether or not the member is 17 years of age or younger.

**Element 16**
Check the box to indicate whether or not the prescription is written by an endocrinologist or through an endocrinology consultation.

**Element 17**
Check the box to indicate whether or not growth hormone will be used for the listed congenital condition(s).

**Element 18**
If growth hormone will not be used for one of the congenital conditions listed in Element 17, prescribers should indicate the medical condition that is being treated in the space provided.

Prescribers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment. Clinical documentation must be attached to each PA request.

**Element 19**
Check the box to indicate whether or not the member had a recent stimulated response growth hormone test. Indicate the type of the most recent stimulated response growth hormone test, the date of the test, and the test result.

Include a copy of the entire stimulation testing procedure information. Clinical documentation must be attached to each PA request.

## SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM ONLY

**Element 20**
Check the box to indicate whether or not the member has a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) wasting disease or cachexia.

## SECTION IIIC — CLINICAL INFORMATION FOR ZORBTIVE ONLY

**Element 21**
Check the box to indicate whether or not the member has a diagnosis of short bowel syndrome with dependence on parenteral nutrition.

## 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 4
# Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs

(A copy of the "Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs" form is located on the following pages.)

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**FORWARDHEALTH**

# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions, F-11092A. 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 Growth Hormone Drugs form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

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

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

**SECTION II — PRESCRIPTION INFORMATION**

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

8. Directions for Use

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

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

12. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

13. Diagnosis Code and Description

Complete the appropriate section of this form:

- PA requests for growth hormone drugs (except Serostim or Zorbtive): complete Section IIIA only.
- PA requests for Serostim: complete Section IIIB only.
- PA requests for Zorbtive: Complete Section IIIC only.

**SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (EXCEPT SEROSTIM OR ZORBTIVE)**

14. Is the drug requested a preferred growth hormone drug? ❑ Yes ❑ No

If the drug is a non-preferred growth hormone drug, describe the reason for the request in the space provided.

15. Is the member 17 years of age or younger? ❑ Yes ❑ No

*Continued*

**SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (EXCEPT SEROSTIM OR ZORBTIVE) (Continued)**

16. Is the prescription for the growth hormone drug written by an endocrinologist or through an endocrinology consultation? ❑ Yes ❑ No

17. Indicate Yes or No if growth hormone will be used for each of the following congenital conditions.
    1. Noonan's syndrome. ❑ Yes ❑ No
    2. Prader Willi syndrome. ❑ Yes ❑ No
    3. Short stature homeobox-containing gene (SHOX) deficiency. ❑ Yes ❑ No
    4. Turner syndrome. ❑ Yes ❑ No

    *Note*: Prior authorization requests for medical conditions not listed above are not available through STAT-PA.

18. If growth hormone will not be used for one of the congenital conditions listed in Element 17, indicate the medical condition that is being treated in the space provided.

    _____

    _____

    Prescribers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment including, but not limited to, the following:
    - Bone age results (pediatric only).
    - Growth charts (including growth rate, growth percentiles and Z- scores) (pediatric only).
    - Growth plate results (pediatric only).
    - Image results.
    - Lab testing.
    - Medical office notes.

19. Does the member have a recent stimulated response growth hormone test? ❑ Yes ❑ No

    Indicate the type and results of most recent stimulated response growth hormone test.

    1. ❑ Arginine Month_____ Year_____ Results_____ng/mL
    2. ❑ Clonidine Month_____ Year_____ Results_____ng/mL
    3. ❑ Glucagon Month_____ Year_____ Results_____ng/mL
    4. ❑ Insulin Month_____ Year_____ Results_____ng/mL
    5. ❑ Other: _____ Month_____ Year_____ Results_____ng/mL

    Additional required information to be submitted with the PA request includes a copy of the entire stimulation testing procedure including, at a minimum:
    - Medical office notes.
    - Growth hormone level from each blood sample taken.
    - Complete test results.
    - Provider interpretation of results.

**SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM ONLY**

20. Does the member have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) wasting disease or cachexia? ❑ Yes ❑ No

**SECTION IIIC — CLINICAL INFORMATION FOR ZORBTIVE ONLY**

21. Does the member have a diagnosis of short bowel syndrome with dependence on parenteral nutrition? ❑ Yes ❑ No

*Continued*

**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 also be included here.

# ATTACHMENT 5
# Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions

(A copy of the "Prior Authorization / Drug Attachment (PA/DGA) Completion Instructions" is located on the following pages.)

# FORWARDHEALTH
# PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA) 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.

Prescribers are required to complete and sign the Prior Authorization/Drug Attachment (PA/DGA), F-11049. Pharmacy providers are required to use the PA/DGA form to request PA by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

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

3) For PA requests submitted by mail, pharmacy providers 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 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 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 — Refills**
Enter the amount 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 — Prescriber**
Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

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

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

## SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/DGA.

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

## SECTIONS IV-VIII

Complete the appropriate sections of this form:

- Section IV for HealthCheck "Other Services" drug requests.
- Section V for diagnosis-restricted drug requests.
- Section VI for drugs with specific PA criteria addressed in the ForwardHealth Online Handbook.
- Section VII for other drug requests.
- Section VIII for additional information when extra space is needed to complete sections IV - VII.

## SECTION IV — CLINICAL INFORMATION FOR HEALTHCHECK "OTHER SERVICES" DRUG REQUESTS

**Element 14**
If the prescriber writes a prescription for a drug that is not covered under the member's ForwardHealth benefit plan, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested through a HealthCheck "Other Services" PA request. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized is required. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

*Note:* All HealthCheck "Other Services" drug PA requests must also include the date of the member's most recent HealthCheck screen, along with the name of the HealthCheck screener (who is required to be Medicaid-enrolled). HealthCheck "Other Services" is limited to members under 21 years of age.

## SECTION V — CLINICAL INFORMATION FOR DIAGNOSIS-RESTRICTED DRUG REQUESTS

**Element 15**
If the prescriber writes a prescription with a diagnosis outside the ForwardHealth-allowed diagnoses for a drug, the prescriber is required to attach peer-reviewed medical literature to support the proven efficacy and safety of the requested use of the drug. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized is required. Medical records should be provided as necessary to support the PA request.

## SECTION VI — CLINICAL INFORMATION FOR DRUGS WITH SPECIFIC CRITERIA ADDRESSED IN THE FORWARDHEALTH ONLINE HANDBOOK

**Element 16**
If the prescriber writes a prescription for a drug that has specific criteria addressed in the ForwardHealth Online Handbook of the ForwardHealth Portal, the prescriber is required to review the Online Handbook criteria and document the required information. Refer to the Prior Authorization Drug Attachment topic in the Prior Authorization section of the ForwardHealth Online Handbook for more information and a list of drugs.

## SECTION VII — CLINICAL INFORMATION FOR OTHER DRUG REQUESTS

**Element 17**
If the prescriber writes a prescription for a drug that requires the use of the PA/DGA form and is not previously referenced in the above sections, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized is required. In addition, if the drug requested is a non-preferred Preferred Drug List (PDL) drug, prescribers are required to specifically address why other preferred PDL drugs cannot be utilized. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

## SECTION VIII — ADDITIONAL INFORMATION

**Element 18**
Indicate any additional information in the space provided. If the space provided in Sections IV to VII is not sufficient, use Section VIII to include any additional information.

## SECTION IX — AUTHORIZED SIGNATURE

**Element 19 — Signature — Prescriber**
The prescriber must review this information and sign this form.

**Element 20 — Date Signed**
Enter the month, day, and year the PA/DGA was signed (in MM/DD/CCYY format).

# ATTACHMENT 6
# Prior Authorization/Drug Attachment (PA/DGA)

(A copy of the "Prior Authorization/Drug Attachment (PA/DGA) form is located on the following pages.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11049 (10/13)

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

**FORWARDHEALTH**

# PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA)

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions, F-11049A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Drug Attachment (PA/DGA) form 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. Refills |

8. Directions for Use

| 9. Name — Prescriber | 10. National Provider Identifier — Prescriber |
|---|---|

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

12. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

13. Diagnosis Code and Description

**SECTIONS IV-VIII**

Complete the appropriate sections of this form:

- Section IV for HealthCheck “Other Services” drug requests.
- Section V for diagnosis-restricted drug requests.
- Section VI for drugs with specific PA criteria addressed in the ForwardHealth Online Handbook.
- Section VII for other drug requests.
- Section VIII for additional information when extra space is needed to complete sections IV - VII.

*Continued*

## SECTION IV — CLINICAL INFORMATION FOR HEALTHCHECK "OTHER SERVICES" DRUG REQUESTS

14. Document the clinical rationale to support the medical necessity of the drug being requested as a HealthCheck "Other Services" PA request. Include documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

    *Note:* All HealthCheck "Other Services" drug PA requests must also include the date of the member's most recent HealthCheck screen, along with the name of the HealthCheck screener (who is required to be Medicaid-enrolled). HealthCheck "Other Services" is limited to members under 21 years of age.

## SECTION V — CLINICAL INFORMATION FOR DIAGNOSIS-RESTRICTED DRUG REQUESTS

15. Submit peer-reviewed medical literature to support the proven efficacy and safety of the requested use of the drug. Include documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized. Medical records should be provided as necessary to support the PA request.

*Continued*

## SECTION VI — CLINICAL INFORMATION FOR DRUGS WITH SPECIFIC CRITERIA ADDRESSED IN THE FORWARDHEALTH ONLINE HANDBOOK

16. Review the ForwardHealth Online Handbook PA criteria on the ForwardHealth Portal and document the required information. Refer to the Prior Authorization Drug Attachment topic in the Prior Authorization section of the ForwardHealth Online Handbook for more information and a list of drugs.

## SECTION VII — CLINICAL INFORMATION FOR OTHER DRUG REQUESTS

17. Document the clinical rationale to support the medical necessity of the drug being requested. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized is required. In addition, if the drug requested is a non-preferred PDL drug, specifically address why other preferred PDL drugs cannot be utilized. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

*Continued*

## SECTION VIII — ADDITIONAL INFORMATION

18. Indicate any additional information in the space below. If the space provided in Sections IV to VII is not sufficient, include any additional information here.

## SECTION IX — AUTHORIZED SIGNATURE

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

# ATTACHMENT 7
# State Maximum Allowed Cost Drug Pricing Review Request Completion Instructions

(A copy of the "State Maximum Allowed Cost Drug Pricing Review Request Completion Instructions" is located on the following page.)

**FORWARDHEALTH**

# STATE MAXIMUM ALLOWED COST DRUG PRICING REVIEW REQUEST COMPLETION INSTRUCTIONS

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

Personally identifiable information about providers is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

The use of the State Maximum Allowed Cost Drug Pricing Review Request form, F-00030, is mandatory when requesting a state maximum allowed cost (state MAC) drug pricing review. Requests for pricing review will not be accepted for Wholesale Acquisition Cost and expanded maximum allowed cost rates on file for a National Drug Code (NDC).

All elements are required unless otherwise noted.

## SECTION I — PHARMACY INFORMATION

**Element 1 — Name — Pharmacy**
Enter the name of the pharmacy.

**Element 2 — National Provider Identifier**
Enter the 10-digit National Provider Identifier of the pharmacy.

**Element 3 — Taxonomy Code (Optional)**
Enter the taxonomy code assigned by ForwardHealth.

**Element 4 — ZIP+4 Code — Practice Location (Optional)**
Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

**Element 5 — Address — Provider**
Enter the address (street, city, state, and ZIP+4 code) of the pharmacy.

**Element 6 —Telephone Number — Provider**
Enter the telephone number, including the area code, of the pharmacy.

**Element 7 — Fax Number — Provider**
Enter the fax number, including the area code, of the pharmacy.

**Element 8 — Name — Contact Person**
Enter the name of the primary contact person at the pharmacy.

## SECTION II — PRODUCT AND PRICE INFORMATION

**Element 9 — NDC**
Enter the appropriate 11-digit NDC for each drug.

**Element 10 — Drug Name**
Enter the drug name.

**Element 11 — Current State MAC Price**
Enter the current state MAC price.

**Element 12 — Net Cost**
Enter the net cost of the drug. (This is the cost after rebates or discounts from a wholesaler or other entity. This value may be lower than the invoiced price.)

**Element 13**
Include a description of the reason for state MAC review (e.g., no generic available at state MAC price).

**Element 14 — Signature — Pharmacist**
The pharmacist is required to complete and sign this form.

**Element 15 — Date Signed**
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

# ATTACHMENT 8
# State Maximum Allowed Cost Drug Pricing Review Request

(A copy of the "State Maximum Allowed Cost Drug Pricing Review Request" form is located on the following page.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-00030 (10/13)

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

**FORWARDHEALTH**

# STATE MAXIMUM ALLOWED COST DRUG PRICING REVIEW REQUEST

**Instructions:** The use of this form is mandatory to request the review of state Maximum Allowed Cost (MAC) pricing in the ForwardHealth drug index. Pharmacists are required to submit documentation to substantiate their actual net cost and sign the certifying statement below. The pharmacy must submit an invoice having a product date of purchase within 60 days of submitting the request. Refer to the State Maximum Allowed Cost Drug Pricing Review Request Completion Instructions, F-00030A, for more information. Requests for pricing review will not be accepted for Wholesale Acquisition Cost and expanded MAC rates on file for a National Drug Code (NDC).

The completed form may be returned to the Drug Authorization and Policy Override Center via fax at (608) 250-0246 or by mail at the following address:

ForwardHealth
Drug Authorization and Policy Override Center
313 Blettner Blvd
Madison WI 53784

**SECTION I — PHARMACY INFORMATION**

| 1. Name — Pharmacy | 2. National Provider Identifier | 3. Taxonomy Code | 4. ZIP+4 Code — Practice Location |
|---|---|---|---|
| | | | |

5. Address — Provider (Street, City, State, ZIP Code)

| 6. Telephone Number — Provider | 7. Fax Number — Provider | 8. Name — Contact Person |
|---|---|---|
| | | |

**SECTION II — PRODUCT AND PRICE INFORMATION**

| 9. NDC (11-Digit No.) | 10. Drug Name | 11. Current State MAC Price | 12. Net Cost* |
|---|---|---|---|
| | | | |

13. Describe the reason for state MAC review (e.g., no generic available at state MAC price).

*** I certify that the price listed on the documentation reflects the actual net costs after rebates or discounts from the wholesaler / supplier.**

| **14. SIGNATURE** — Pharmacist | 15. Date Signed |
|---|---|
| | |

**Internal Use Only**

F-00030

# ATTACHMENT 9
# 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.)

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**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 requests submitted on the ForwardHealth Portal, prescribers can access *www.forwardhealth.wi.gov/.*

3) 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.

4) 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 10-digit 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 should indicate their name and NPI as the billing provider on the PA request.

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

## SECTION II — PRESCRIPTION INFORMATION

**Element 10 — Drug Name**
Enter the drug name.

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

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

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

**Element 14 — Refills**
Enter the number of refills.

## SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for 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 the 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**
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

# ATTACHMENT 10
# Prior Authorization Drug Attachment for Synagis® Completion Instructions

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

**FORWARDHEALTH**

# PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SYNAGIS®
# 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.

Prior authorization requests for Synagis® submitted on paper 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 Synagis® form, F-00142, to request PA for Synagis®. Prescribers are required to retain a completed copy of the form.

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

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

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

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

4) For PA requests submitted by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment 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).

The following table includes the weight range, the rounded calculated Synagis® dose, and the number of 50 mg units of Synagis® and is used for the adjudication of PA requests to determine the allowed billing units.

| Weight Range (in kg) | Synagis® Calculated Dose | Number of Units* |
|---|---|---|
| Up to 3.6 kg | 0 - 54 mg | 1 |
| 3.7 to 6.9 kg | 55 mg - 104 mg | 2 |
| 7.0 to 10.2 kg | 105 mg - 154 mg | 3 |
| 10.3 to 13.6 kg | 155 mg - 204 mg | 4 |
| 13.7 to 16.9 kg | 205 mg - 254 mg | 5 |
| 17.0 to 20.3 kg | 255 mg - 304 mg | 6 |

* Units are a 50 mg dose.

**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 medical practitioner prescribing the medication for PA.

**Element 5 — National Provider Identifier (NPI) — Prescriber**
Enter the prescribing provider's 10-digit 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. If a prescriber or a prescriber's clinic or group intends to submit the claim, enter the prescriber or prescriber's clinic or group name. If a pharmacy intends to submit the claim, enter the pharmacy's name.

**Element 9 — NPI — Billing Provider**
Enter the NPI of the billing provider. If a prescriber or a prescriber's clinic or group intends to submit the claim, enter the prescriber or prescriber's clinic or group NPI. If a pharmacy intends to submit the claim, enter the pharmacy's NPI..

**SECTIONS IIA, IIB, IIC, or IID**
Providers are required to complete *one* of either Section IIA, IIB, IIC, or IID *or* Section V for a PA request to be considered for approval. Providers should indicate the reason for administration of Synagis®. Under the appropriate condition, check the boxes that apply to the member's medical condition. Include the last date of therapy treatment in the chronic lung disease section. For a pre-term infant, the gestational age at delivery must be included.

**SECTION IIA — CLINICAL INFORMATION FOR CHRONIC LUNG DISEASE**

**Element 10**
Indicate whether or not the member is a child younger than 24 months of age at the start of the respiratory syncytial virus (RSV) season with chronic lung disease who required bronchodilator, corticosteroid, diuretic, or supplemental oxygen therapy within six months of the start of the RSV season.

**SECTION IIB — CLINICAL INFORMATION FOR CONGENITAL HEART DISEASE**

**Element 11**
Indicate whether or not the member is a child younger than 24 months of age at the start of the RSV season who has hemodynamically significant cyanotic or acyanotic congenital heart disease and is receiving medication to control congestive heart failure, has moderate to severe pulmonary hypertension, or has cyanotic heart disease.

**SECTION IIC — CLINICAL INFORMATION FOR IMMUNOCOMPROMISED CHILDREN**

**Element 12**
Indicate whether or not the member is a child younger than 24 months of age at the start of the RSV season with a severe immunodeficiency (i.e., severe combined immunodeficiency [SCID] or advanced Acquired Immune Deficiency Syndrome [AIDS]).

**SECTION IID — CLINICAL INFORMATION FOR PRE-TERM INFANTS**

**Element 13**
Indicate the pre-term infant's gestational age at delivery in weeks and days. Check the appropriate box to indicate the member's clinical condition.

**Element 14**
Indicate whether or not the first dose of Synagis® was administered when the child was hospitalized. Indicate the date the first dose was administered. If the first dose of Synagis® was administered when the child was hospitalized, indicate the date the first dose was administered in MM/DD/CCYY format.

**Element 15 — Current Weight — Member**
Enter the child's current weight in kilograms.

**Element 16 — Date Member Weighed**
Enter the date the child was weighed.

**Element 17 — Calculated Dosage of Synagis®**
Enter the monthly dose of Synagis® in milligrams needed based on the calculation of 15 milligrams per kilogram of body weight.

## SECTION IV — AUTHORIZED SIGNATURE

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

**Element 19 — Date Signed — Prescriber**
Enter the month, day, and year the form was signed by the prescriber in MM/DD/CCYY format.

## SECTION V — ADDITIONAL INFORMATION

**Element 20**
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

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