ForwardHealth
Wisconsin serving you

Update
September 2014

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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Blood Banks, Dentists, Federally Qualified Health Centers, Hospital Providers, 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 October 1, 2014

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to pharmacy policies effective for dates of service on and after October 1, 2014, unless otherwise noted.

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This *Update* addresses changes to pharmacy policies for the following:

- Growth Hormone Drugs.
- Hepatitis C, Agents.
- Hypoglycemics, Glucagon-Like Peptide Agents.
- Multiple Sclerosis (MS) Agents, Immunomodulators.
- Stimulants and Related Agents.
- Crinone®.
- Kalydeco®.
- Naltrexone.
- Hospice services for members who are 20 years of age or younger.
- Uploading prior authorization (PA) attachments using the ForwardHealth Portal.

Changes to Pharmacy-Related Forms and Completion Instructions

ForwardHealth no longer includes copies of revised forms and completion instructions as attachments to pharmacy *Updates*. The Attachment of this *Update* lists the PA forms and completion instructions that are new or have been revised, renamed, or discontinued as a result of pharmacy policy changes. Providers should refer to the Forms page of the Portal for current copies of all PA forms and completion instructions. Unless otherwise noted, all forms listed in the Attachment are effective October 1, 2014. Additional information regarding changes to clinical criteria or submission options is noted under the applicable pharmacy policy area in this *Update*.

Archive Page for Pharmacy-Related Forms and Completion Instructions

Providers may reference the Pharmacy-Related Forms and Completion Instructions link under the Archives section on the Pharmacy Resources page of the Portal for old versions of pharmacy-related forms and completion instructions. These archives are provided for reference purposes only. Providers should refer to the ForwardHealth Online Handbook for current policy and procedures and to the Forms page for current forms and completion instructions.

Growth Hormone Drugs

Prior Authorization/Preferred Drug List for Growth Hormone Drugs Form Has Been Revised

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092 (10/14). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after October 1, 2014, must be submitted on the revised form or they will be returned.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Prior authorization requests for growth hormone drugs may be submitted using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system (for some conditions or indications), on the ForwardHealth Portal, by fax, or by mail.

Initial PA requests for growth hormone drugs may be approved for up to a maximum of 183 days. Renewal PA requests may be approved for up to a maximum of one year.

ForwardHealth has revised the clinical criteria for growth hormone drugs for pediatric-covered indications. Clinical criteria for growth hormone drugs for other indications have not changed. (For more information about coverage of growth hormone drugs, providers may refer to the Growth Hormone Drugs topic [topic #1988] in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.)

The two key changes to the clinical criteria for growth hormone drugs for pediatric indications are the following:

- Growth failure or short stature associated with growth hormone deficiency must be confirmed with at least two appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than 10 ng/mL. (Previously, only one stimulation test was required.)
- Hypothalamic-pituitary structural lesions and evidence of panhypopituitarism only need to involve two pituitary hormone deficiencies, not including growth hormone, in order to support the need for growth hormone treatment. (Previously, at least three pituitary hormone deficiencies needed to be involved.)

Clinical Criteria for Pediatric-Covered Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Growth failure or short stature associated with one of the following congenital conditions:
  - ✓ Noonan's Syndrome.
  - ✓ Prader Willi Syndrome.
  - ✓ Short stature homeobox-containing (SHOX) deficiency.
  - ✓ Turner Syndrome.
- Growth failure or short stature associated with chronic renal insufficiency in pre-transplant members. Providers are required to 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 at least two appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than 10 ng/mL. The member's height must be less than two standard deviations below the mean for chronological age. Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.
- Members born small for gestational age who are 2 years of age or older with a height that remains less than two standard deviations below the mean for chronological age. Providers are required to 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 two pituitary hormone deficiencies, not including growth hormone. Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.

Detailed documentation of the medical work-up and testing includes, at a minimum:

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

Additional required documentation to be submitted with the PA request when applicable includes the following:

- Bone age results.
- Growth plate results.
- Other image results.
- Growth hormone stimulation results.

Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol. Complete testing results must be included with the PA request. The testing results must include the type of stimulation test and the dose of stimulating agent, a copy of the medical notes taken during the entire testing procedure, the time and results from each blood sample taken, and the provider interpretation of the testing results.

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

Hepatitis C, Agents

Revised Prior Authorization Drug Attachment for Sovaldi™ Form

ForwardHealth has revised the Prior Authorization Drug Attachment for Sovaldi™, F-01247 (10/14). The revised form provides clarification regarding the documentation that must be submitted with PA requests for Sovaldi. The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after October 1, 2014, must be submitted on the revised form or they will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Pharmacy providers may submit PA requests for Sovaldi™ on the Portal, by fax, or by mail. Prior authorization requests for Sovaldi™ may *not* be submitted using the STAT-PA system.

Only PA requests for Sovaldi™ for members whose hepatitis C liver disease has advanced to any of the following stages may be considered for review:

- Compensated cirrhosis.
- Metavir score of F3 or greater or evidence of bridging fibrosis.
- Hepatocellular carcinoma (HCC), if the member is on a liver transplant waiting list.
- Serious extra-hepatic manifestations of hepatitis C virus (HCV).

In addition, only HCV treatment prescribed by a gastroenterologist or infectious disease provider practice for a member who is 18 years of age or older will be considered for review.

The decision to treat chronic hepatitis C is not always urgent and involves discussion with the member about the

risks and benefits of treatment, the need for compliance with drug protocols, the side effects associated with prolonged use of a drug, and the rapidly changing breakthrough drug therapies that are currently in development for hepatitis C treatment. Prescribers should also carefully assess factors that may affect patient adherence, such as social supports, neurocognitive disorders, and active substance abuse.

In cases where the member does not meet the above review criteria, the provider and member may decide to proceed with treatment using preferred hepatitis C drugs.

ForwardHealth has revised the clinical information that must be documented on an initial PA request for Sovaldi™.

Clinical Information That Must Be Documented on Initial Prior Authorization Requests for Sovaldi™

For initial PA requests for Sovaldi™, prescribers should complete the Prior Authorization Drug Attachment for Sovaldi™ and submit the form to the pharmacy where the prescription will be filled. Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Sovaldi™ and a completed Prior Authorization Request Form (PA/RF), F-11018 (05/13), to ForwardHealth.

If applicable, the clinical information that must be documented on an initial PA request for Sovaldi™ are **all** of the following:

- Lab data, including the following:
  - ✓ Hepatitis C virus genotype.
  - ✓ Hepatitis C virus-ribonucleic acid (HCV-RNA) level.
  - ✓ Liver function tests.
  - ✓ Complete blood count.
  - ✓ Serum creatinine test.
  - ✓ Albumin test.
  - ✓ International normalized ratio.
  - ✓ Liver biopsy, scan, or ultrasound results (if performed).
- Hepatitis C virus clinical data, including the following:
  - ✓ Likely source of the HCV infection.
  - ✓ Current medical records for hepatitis C assessment and treatment.
  - ✓ History of liver transplant or on liver transplant wait list.
  - ✓ Clinical assessment of presence or absence of cirrhosis.
  - ✓ If cirrhotic, documentation of the following:
    - o Child-Turcotte-Pugh score.
    - o Clinical evidence of the state of compensation.
    - o Hepatocellular carcinoma status based on imaging study within the last six months.
  - ✓ Fibrosis stage or score.
- Hepatitis C medication treatment history, including the following:
  - ✓ Details of when treatment occurred.
  - ✓ Medications taken and compliance.
  - ✓ Treatment results (e.g., null response, partial response, or relapse.)
- Current medication list.
- Relevant medical history not related to hepatitis C, including the following:
  - ✓ Other liver disease.
  - ✓ Transplant history.
  - ✓ Hepatitis A, hepatitis B, or Human Immunodeficiency Virus coinfection.
  - ✓ Autoimmune disease.
  - ✓ Information regarding birth control counseling the member has received. (*Note:* Two forms of birth control should be utilized when ribavirin-containing treatment regimen is prescribed. If the member is of child-bearing age, documentation of a negative pregnancy test must be submitted with the PA request).
  - ✓ Current and historical alcohol abuse or illicit drug use. (*Note:* Documentation of at least six months of abstinence from alcohol abuse or illicit drug use must be submitted with the PA request).

- ✓ Other significant or uncontrolled diseases (e.g., depression, thyroid disease, diabetes, cardiovascular disease, pulmonary disease).
- Planned hepatitis C treatment regimen.

Prior authorization requests for an interferon-free treatment regimen of Sovaldi™ and ribavirin in HCV Genotype 1 may be considered for review in the following circumstances:

- The member has a platelet count less than 75,000/mm3.
- The member has a severe mental health conditions(s) that may be exacerbated by interferon or respond poorly to medical therapy (with risks of interferon use documented by mental health evaluation). If a mental health condition(s) is the basis for the member being unable to take interferon alfa, documentation from the member's mental health provider must be submitted with the PA request.
- The member has an autoimmune disease(s) that may be exacerbated by interferon-medicated immune modulation.
- The member was unable to complete a prior treatment course due to documented interferon-related adverse effects.

Prescribers are required to document these circumstances using Section V (Additional Information) of the Prior Authorization Drug Attachment for Sovaldi™ or by submitting additional supporting clinical documentation with the PA request.

If the required documentation is not included on or with the Prior Authorization Drug Attachment for Sovaldi™, the PA request will be considered incomplete and will be returned to the provider or denied.

Initial PA requests for Sovaldi™ may be approved for up to a maximum of eight weeks. Depending on the treatment course that has been approved, PA requests may be renewed for additional weeks if the member's HCV-RNA is less than 25 IU/ml.

Renewal Prior Authorization Requests for Sovaldi™

For renewal PA requests for Sovaldi™, prescribers should complete the Prior Authorization Drug Attachment for Sovaldi™ Renewal, F-01248 (07/14), and submit the form to the pharmacy where the prescription will be filled. The member's HCV-RNA levels are required to be submitted with each renewal PA request for Sovaldi™. Pharmacy providers are required to submit to ForwardHealth the completed Prior Authorization Drug Attachment for Sovaldi™ Renewal and a completed Prior Authorization Amendment Request, F-11042 (07/12). A PA/RF should *not* be submitted.

Conditions or Circumstances for Which Prior Authorization Requests Will Be Denied

Prior authorization requests for Sovaldi™ will be denied in the following circumstances:

- The member has autoimmune hepatitis or other conditions that are contraindications for interferon or ribavirin.
- The member has a significant or uncontrolled concurrent disease (e.g., depression, thyroid disease, diabetes, cardiovascular disease, pulmonary disease).
- The member has decompensated cirrhosis.
- The member has acute hepatitis C.
- The member has received a liver transplant.
- The member is currently abusing illicit drugs or alcohol.
- Non-compliance with approved hepatitis C treatment regimen (for renewals only).

Hypoglycemics, Glucagon-Like Peptide Agents

Prior Authorization/ Preferred Drug List for Glucagon-Like Peptide Agents Form Has Been Revised

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents, F-00238 (10/14). The previous version will be removed from the Forms page of the Portal and placed

on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after October 1, 2014, must be submitted on the revised form or they will be returned.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

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

Prior authorization requests for non-preferred GLP-1 agents may be submitted on the Portal, by fax, or by mail. Prior authorization requests for non-preferred GLP-1 agents may *not* be submitted using the STAT-PA system.

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

ForwardHealth has revised the clinical criteria for Byetta and the clinical criteria for non-preferred GLP-1 agents.

Clinical Criteria for Byetta

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

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

Clinical Criteria for Non-preferred GLP-1 Agents

Clinical criteria for approval of a PA request for a non-preferred GLP-1 agent (including Bydureon or Victoza) are *all* of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is *not* currently being treated with rapid-acting, short-acting, intermediate-acting, or premixed insulin injections. (*Note:* For Bydureon approval, the member is not currently being treated with *any* insulin.)
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member's HbA1c was measured within the past six months.
- If the member is *not* currently using a GLP-1 agent, his or her most recent HbAc1 is 6.5 percent or greater.

- *One* of the following applies to the member:
  - ✓ The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin.
  - ✓ The member is unable to take the maximum effective dose of metformin.
- The member has taken the maximum dose of Byetta for *at least three* consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

Multiple Sclerosis Agents, Immunomodulators

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators form, F-00805 (10/14). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after October 1, 2014, must be submitted on the revised form or they will be returned to the provider.

Medical records *must* be submitted with the PA request to support the need for a non-preferred oral immunomodulator or Copaxone® 40 mg.

Prior Authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Pharmacy providers may submit PA requests for non-preferred immunomodulators on the Portal, by fax, or by mail. Prior authorization requests for non-preferred immunomodulators may *not* be submitted using the STAT-PA system.

If clinical criteria for non-preferred immunomodulators for treatment of MS are met, initial PA requests may be approved for up to a maximum of 183 days. Renewal requests may be approved for up to a maximum of one year.

Providers should refer to the Multiple Sclerosis Agents, Immunomodulators topic (topic #10997) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook for clinical criteria for non-preferred MS immunomodulators.

Stimulants and Related Agents

Revised Prior Authorization Drug Attachment for Modafinil and Nuvigil® Form

ForwardHealth has revised the Prior Authorization Drug Attachment for Modafinil and Nuvigil®, F-00079 (10/14). The previous version of this form will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after October 1, 2014, must be submitted on the revised form or they will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Pharmacy providers may submit PA requests for modafinil or Nuvigil® on the Portal, by fax, or by mail. Prior authorization requests for modafinil or Nuvigil® may *not* be submitted through the STAT-PA system.

If clinical criteria for modafinil or Nuvigil® are met, initial PA requests may be approved for up to a maximum of 183 days. Renewal PA requests for modafinil or Nuvigil® may be approved for up to a maximum of one year.

ForwardHealth has revised the dose limit policy for modafinil.

Note: Clinical criteria for drugs in the stimulants and related agents drug class, including modafinil, have not changed.

For more information on coverage of stimulants and related agents, providers may refer to the Stimulants and Related Agents topic (topic #16357) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Dose Limit for Modafinil

The dose limit for modafinil is 200 mg per day.

ForwardHealth will only consider modafinil dose limit overrides up to 400 mg per day for members who meet the following criteria:

- The member has a diagnosis of narcolepsy.
- The member is not taking any hypnotics, sleep aids, or other medications that can cause sleepiness.
- The member has experienced a partial response to modafinil 200 mg per day.

For members with an existing approved PA request for modafinil, a dose limit override may be requested using the Prior Authorization Amendment Request. For members without an existing PA request for modafinil, the Prior Authorization Drug Attachment for Modafinil and Nuvigil® must be submitted.

The following documentation must be submitted with all modafinil dose limit override requests:

- A list of the medication(s) the member is currently taking or has previously taken for narcolepsy.
- A history of the member's modafinil use and justification for why the member needs a dose above the Food and Drug Administration-approved dose of 200 mg per day.

Crinone®

Prior authorization requests for Crinone® may be approved for treatment of the following conditions:

- Secondary amenorrhea.
- Prevention of preterm birth in women with short cervical length.

Although Crinone® is also indicated for use in assisted reproductive technology (ART) treatment, ForwardHealth does not cover infertility treatment, including ART.

Prior authorization requests for Crinone® must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the Online Handbook) of the Prior Authorization Drug Attachment (PA/DGA), F-11049 (10/13), and the PA/RF. The gestational age (if applicable), in weeks and days, of the pregnancy must be indicated in Section VI of the PA/DGA.

Prior authorization requests for Crinone® may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Crinone® may *not* be submitted using the STAT-PA system.

ForwardHealth has established clinical criteria for Crinone®.

Clinical Criteria for Crinone® for Members Who Have Secondary Amenorrhea

Secondary amenorrhea is the cessation of menses for six or more months in a woman who previously had normal menstrual cycles. Women who are pregnant, breastfeeding, or in menopause are not considered to have secondary amenorrhea.

Clinical criteria that must be documented for approval of a PA request for Crinone® for members who have secondary amenorrhea are *all* of the following:

- The member has a diagnosis of secondary amenorrhea.
- The member's last menstrual cycle occurred more than six months ago.
- The member is *not* being treated for infertility.
- The member is not pregnant or breastfeeding.
- The member is not in menopause.
- The member is currently receiving estrogen therapy.

Crinone® 4% will only be approved for every other day dosing up to a total of six doses.

In women who fail to respond to a trial of Crinone® 4%, Crinone® 8% will only be approved for every other day dosing up to a total of six doses.

Clinical Criteria for Crinone® for Women with Short Cervical Length

Short cervical length is associated with an increased risk of preterm birth.

Clinical criteria that must be documented for approval of a PA request for Crinone® for prevention of preterm birth in a woman with short cervical length are *both* of the following:

- The member is pregnant with a singleton pregnancy.
- The member has a short cervix, defined as cervical length of less than 25 mm at less than 28 weeks gestation. (*Note:* Short cervical length must be determined by transvaginal ultrasound. Neither digital examination nor transabdominal ultrasound is an acceptable means of determination of short cervical length.)

For women with short cervical length, documentation indicating the gestational age, in weeks and days, must be included with the PA request.

Prior authorization requests for Crinone® for women with short cervical length may be approved regardless of whether or not the woman has a history of spontaneous preterm birth.

Crinone® 8% for daily dosing will be approved through 36 weeks gestation.

Kalydeco®

Kalydeco® (ivacaftor) requires PA and is only indicated for the treatment of a rare form of cystic fibrosis with a G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene. Prior authorization requests for Kalydeco® must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the Online Handbook) of the PA/DGA and the PA/RF.

Prior authorization requests for Kalydeco® may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Kalydeco® may *not* be submitted using the STAT-PA system.

ForwardHealth has revised the clinical criteria that must be documented for approval of a PA request for Kalydeco®.

Clinical Criteria for Kalydeco®

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

- The member has a diagnosis of cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed that the member has a G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene. (*Note:* A copy of the test results should be included with an initial PA request.)
- The prescriber has confirmed that the member does not have a homozygous F508del mutation in the CFTR gene.
- The prescriber has confirmed that liver function testing is being periodically monitored. (*Note:* A copy of the test results completed within the last 90 days should be included with initial and renewal PA requests.)

Prior authorization requests for Kalydeco® may be approved for up to a maximum of one year.

Naltrexone

Naltrexone will now be a diagnosis-restricted drug. Providers may refer to the Diagnosis Restricted Drugs data table for the most current list of diagnosis-restricted drugs and allowable diagnosis codes.

Hospice Services for Members Who Are 20 Years of Age or Younger

In compliance with requirements of the Affordable Care Act (ACA), ForwardHealth implemented policy in 2010 to

allow members 20 years of age or younger who elect hospice services to receive any medically necessary BadgerCare Plus- or Medicaid-covered services concurrently with hospice care, as long as those services are not duplicative of services covered under the hospice benefit. Prior to enactment of the ACA, curative treatment of a member's terminal illness ceased upon election of the hospice benefit.

Members 20 years of age or younger who elect the hospice benefit are required to use the Election of Hospice Benefit for Members 20 and Under form, F-01009A (12/10). Members 21 years of age or older are required to use the Election of Hospice Benefit for Members 21 and Older form, F-01009B (12/10). As a reminder, the hospice is responsible for notifying ForwardHealth of the member's hospice election by completing the Hospice Benefit form online or by completing and sending in the paper Notification of Hospice Benefit Election, F-1008 (10/08).

Uploading Prior Authorization Attachments and Additional Supporting Documentation Using the Portal

ForwardHealth has extended its Portal capabilities to provide pharmacy providers with an additional submission option. Pharmacy providers can now upload PA attachment forms, in addition to supporting documentation, to the Portal for submission with PA requests. Prior authorization attachment forms must be completed, signed, and dated by prescribers before being uploaded to the Portal.

For additional information about uploading documents to the Portal, providers may refer to the following:

- The Submission Options chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.
- The Upload Documents for a Prior Authorization section of the Prior Authorization User Guide, which is available on the Portal User Guides page of the Portal at *www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/userguides.htm.spage*.

Providers may continue to submit PA attachment forms to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers should not submit more than one copy of the PA attachment to ForwardHealth regardless of the submission method (fax, mail, Portal).

For More Information

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

Information Regarding Managed Care Organizations

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

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS 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 09/17/2014 and information contained in this *Update* was incorporated into the Online Handbook on 10/01/2014.

ATTACHMENT
Changes to Pharmacy Prior Authorization Forms and Completion Instructions

The table below lists the pharmacy prior authorization forms and completion instructions that are new or have been revised, renamed, or discontinued as a result of pharmacy policy changes effective for dates of service on and after October 1, 2014. Providers should refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for current copies of these forms and completion instructions. The old versions of these forms and completion instructions will be moved to the Pharmacy-Related Forms and Completion Instructions archive page that is linked under the Archives section on the Pharmacy Resources page of the Providers area of the Portal. Additional information regarding changes to clinical criteria or submission options is noted under the applicable sections of this *ForwardHealth Update*.

Form Name	Form Number	Revised, Renamed, Discontinued, or New	Effective Date
Prior Authorization Drug Attachment for Modafinil® and Nuvigil®	F-00079	Revised	10/01/14
Completion Instructions	F-00079A	Revised	10/01/14
Prior Authorization Drug Attachment for Sovaldi™	F-01247	Revised	10/01/14
Completion Instructions	F-01247A	Revised	10/01/14
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents	F-00238	Revised	10/01/14
Completion Instructions	F-00238A	Revised	10/01/14
Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs	F-11092	Revised	10/01/14
Completion Instructions	F-11092A	Revised	10/01/14
Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators	F-00805	Revised	10/01/14
Completion Instructions	F-00805A	Revised	10/01/14