

## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR CYMBALTA FOR GENERALIZED ANXIETY DISORDER (GAD) COMPLETION INSTRUCTIONS

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

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

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

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

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD), F-00283. Pharmacy providers are required to use the PA/PDL for Step Therapy for Cymbalta for GAD form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For requests submitted on the ForwardHealth Portal, providers may access [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).
- 3) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 4) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

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

*Note:* A step therapy policy applies for Cymbalta. Members must try and fail paroxetine and venlafaxine before PA may be requested for Cymbalta.

### 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

This element is populated with Cymbalta.

### Element 5 — Drug Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Refills

Enter the number of refills.

### Element 8 — Directions for Use

Enter the directions for use of the drug.

### Element 9 — Name — Prescriber

Enter the name of the prescriber.

### Element 10 — National Provider Identifier (NPI) — Prescriber

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

### Element 11 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

### Element 12 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

## SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Step Therapy for Cymbalta for GAD form.

### Element 13 — Diagnosis Code and Description

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

### Element 14

Indicate whether or not the member has a diagnosis of GAD.

## SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PAROXETINE

### Element 15

Indicate whether or not the member has previously taken paroxetine.

### Element 16

Indicate whether or not the member has taken any formulation of paroxetine for GAD and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates paroxetine was taken in the space provided.

### Element 17

Indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and paroxetine. If yes, list the medication(s) and interaction(s) in the space provided.

### Element 18

Indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking paroxetine. If yes, list the medical condition(s) or contraindication(s) in the space provided.

**SECTION III B — CLINICAL INFORMATION FOR PREVIOUS USE OF VENLAFAXINE**

**Element 19**

Indicate whether or not the member has taken any formulation of venlafaxine for GAD and experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction. If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates venlafaxine was taken in the space provided.

**Element 20 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 21 — Date Signed**

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

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

**Element 22 — National Drug Code**

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

**Element 23 — Days' Supply Requested**

Enter the requested days' supply.

**Element 24 — NPI**

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

**Element 25 — Date of Service**

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

**Element 26 — Place of Service**

Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

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

**Element 27 — Assigned PA Number**

Enter the PA number assigned by the STAT-PA system.

**Element 28 — Grant Date**

Enter the date the PA was approved by the STAT-PA system.

**Element 29 — Expiration Date**

Enter the date the PA expires as assigned by the STAT-PA system.

**Element 30 — Number of Days Approved**

Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 31**

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