

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 (HFS 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.

Attach the completed Prior Authorization/Drug Attachment (PA/DGA), F-11049, to the Prior Authorization Request Form (PA/RF), F- 11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

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

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 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 3 — 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.

SECTION II — TYPE OF REQUEST

Element 4

Indicate the start date requested for PA or the date the prescription was filled.

Element 5

Check the appropriate box to indicate if this product has been requested previously.

SECTION III — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 6 — Drug Name

Enter the drug name.

Element 7 — Strength

Enter the strength of the drug listed in Element 6.

Element 8 — Quantity Ordered

Enter the quantity that was ordered.

Element 9 — Date Order Issued

Enter the date the order was issued.

Element 10 — Directions for Use

Enter the directions for use of the drug.

Element 11 — Daily Dose

Enter the daily dose.

Element 12 — Refills

Enter the amount of refills.

Element 13 — Name — Prescriber

Enter the name of the prescriber.

Element 14 — National Provider Identifier

Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

Element 15

Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

SECTION IV — CLINICAL INFORMATION

Include diagnostic, as well as clinical information, explaining the need for the product requested.

Element 16

List the member's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes and the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if more space is required.

Element 17

Indicate source of clinical information.

Element 18

Indicate use of the product requested.

Element 19

Indicate dosage of the product requested.

Element 20 — Signature — Pharmacist or Dispensing Physician

The pharmacist / dispenser must review this information and sign this form.

Element 21 — Date Signed

Enter the month, day, and year the PA/DGA was signed (in MM/DD/CCYY format).