

## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST COMPLETION INSTRUCTIONS

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

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

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

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

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075. Pharmacy providers are required to use the PA/PDL Exemption Request form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal 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).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

#### Element 3 — Date of Birth — Member

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

## SECTION II — PRESCRIPTION INFORMATION

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

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Drug Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier (NPI) — Prescriber

Enter the 10-digit National Provider Identifier (NPI) of the prescriber for prescriptions for non-controlled substances.

### Element 10 — Address — Prescriber

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

### Element 11 — Telephone Number — Prescriber

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

## SECTION III — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 15, check "yes" to all that apply.

### Element 12 — Diagnosis Code and Description

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

### Element 13

Check the appropriate box to indicate whether or not the member has experienced treatment failure with the preferred drug(s). If yes is checked, indicate in the space provided the most recently failed preferred drug(s), the specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken.

### Element 14

Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents the use of the preferred drug(s). If yes is checked, indicate in the space provided the member's medical condition(s) that prevent the use of the preferred drug(s).

### Element 15

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and the preferred drug(s). If yes is checked, indicate in the space provided the medication(s) and the drug interaction(s).

### Element 16

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction while taking the preferred drug(s). If yes is checked, indicate in the space provided the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken.

**Element 17**

Check the appropriate box to indicate whether or not the member has taken the requested non-preferred grandfathered drug in any of the following drug classes for more than 30 days outside ForwardHealth and had a measurable, therapeutic response. The drug classes include anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics.

**Element 18 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 19 — 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 20 — National Drug Code**

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

**Element 21 — Days' Supply Requested**

Enter the requested days' supply.

**Element 22 — NPI**

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

**Element 23 — 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 24 — 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 25 — Assigned PA Number**

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

**Element 26 — Grant Date**

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

**Element 27 — Expiration Date**

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

**Element 28 — 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 29**

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