

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-  
OXYGENASE INHIBITORS, COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information applies to Medicaid and SeniorCare.

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 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 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, F-11077. Pharmacy providers are required to use the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors 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, prescribers can 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.

### 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

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form. Complete Section III A for PA requests for NSAIDs including cyclo-oxygenase inhibitors or Section III B for PA requests for cyclo-oxygenase inhibitors only.

### Element 12 — Diagnosis Code and Description

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

## SECTION IIIA — CLINICAL INFORMATION FOR NONSTEROIDAL ANTI-INFLAMMATORY DRUGS, INCLUDING CYCLO-OXYGENASE INHIBITORS

### Element 13

Check the appropriate box to indicate whether or not the member has tried and failed two preferred, generic NSAIDs or experienced an adverse drug reaction. (The two preferred, generic NSAIDs taken cannot include ibuprofen or naproxen.) If yes, check the boxes to indicate the two NSAIDs that were taken, and list the specific details about the treatment failures or adverse drug reactions and the approximate dates the two preferred, generic NSAIDs were taken in the space provided.

## SECTION IIIB — CLINICAL INFORMATION FOR CYCLO-OXYGENASE INHIBITORS ONLY

### Element 14

Check the appropriate box to indicate if the member has a history of familial adenomatous polyposis (FAP).

### Element 15

Check the appropriate box to indicate if the member has medical record documentation of thrombocytopenia or platelet dysfunction.

### Element 16

Check the appropriate box to indicate if the member has medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding.

### Element 17

Check the appropriate box to indicate if the member is currently taking oral anticoagulation therapy.

**Element 18**

Check the appropriate box to indicate if the member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.

**Element 19**

Check the appropriate box to indicate if the member is 65 years of age or older.

**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 — AUTHORIZED SIGNATURE**

**Element 29 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 30 — Date Signed**

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

**SECTION VI — ADDITIONAL INFORMATION**

**Element 31**

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