

## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS 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. Prescribers and dispensing physicians are required to retain a completed copy of the form.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents, F-11097. Pharmacy providers are required to use the PA/PDL for Stimulants and Related Agents 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 submit a copy of the prescription.

### 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 complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

### Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 12 — Diagnosis Code and Description

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

## SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Intuniv, Kapvay, and Strattera.)

### Element 13

Check the appropriate box to indicate whether or not the member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants. If yes is checked, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

## SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA REQUESTS

### Element 14

Check the appropriate box to indicate whether or not the member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants. If yes is checked, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

### Element 15

Check the appropriate box to indicate whether or not the member has a medical condition(s) (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant. If yes is checked, list the medical condition(s) in the space provided.

### Element 16

Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse. If yes is checked, explain in the space provided.

### Element 17

Check the appropriate box to indicate whether or not the member has a serious risk of drug diversion. If yes is checked, explain in the space provided.

**SECTION III C — CLINICAL INFORMATION FOR INTUNIV AND KAPVAY REQUESTS**

**Element 18**

Check the appropriate box to indicate whether or not the member will take Intuniv or Kapvay in combination with a preferred stimulant. If yes is checked, list the preferred stimulant in the space provided.

**Element 19**

Check the appropriate box to indicate whether or not the member experienced a treatment failure with a preferred stimulant. If yes is checked, list the preferred stimulant, specific details about the treatment failure, and the approximate date(s) the preferred stimulant was taken in the space provided.

**Element 20**

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

**Element 21**

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

**Element 22**

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction to a preferred stimulant. If yes is checked, list the name of the preferred stimulant, specific details about the clinically significant adverse drug reaction, and the approximate dates of the adverse drug reaction in the space provided.

**SECTION IV — AUTHORIZED SIGNATURE**

**Element 23 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 24 — Date Signed**

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

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

**Element 25 — National Drug Code**

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

**Element 26 — Days' Supply Requested**

Enter the requested days' supply up to 365 days.

**Element 27 — NPI**

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

**Element 28 — 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 29 — 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 30 — Assigned PA Number**

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

**Element 31 — Grant Date**

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

**Element 32 — Expiration Date**

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

**Element 33 — Number of Days Approved**

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

**SECTION VI — ADDITIONAL INFORMATION**

**Element 34**

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.