

## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR SYMLIN 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 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.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Symlin, F-00080. Pharmacy providers are required to use the PA/PDL for Symlin 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

### Element 4 — Drug Name

Enter the name of the drug.

### Element 5 — Drug Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date that 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

### 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. The diagnosis code indicated must be an allowable diagnosis code for Symlin.

### Element 14

Enter the member's most current hemoglobin (HbA1c) test results.

### Element 15 — Date Member's HbA1c Measured

Enter the date of the HbA1c test from Element 14 in MM/DD/CCYY format. The date must be within a year of the requested start date.

### Element 16

Indicate whether or not the member is using Symlin for weight loss.

### Element 17

Indicate whether or not the member is currently receiving insulin injections.

### Element 18

Indicate whether or not the member is currently receiving meal-time insulin injections.

### Element 19

Indicate whether or not the member is 18 years of age or older.

### Element 20

Indicate whether or not the member currently has or has a history of gastroparesis.

### Element 21

Indicate whether or not the member currently has or has a history of hypoglycemia unawareness.

**Element 22**

Indicate whether or not the member has required emergency treatment for severe hypoglycemia in the past six months and, if yes, check the appropriate box to indicate how many times.

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

**Element 23 — National Drug Code**

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

**Element 24 — Days' Supply Requested**

Enter the requested days' supply.

**Element 25 — NPI**

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

**Element 26 — 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 27 — 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 28 — Assigned PA Number**

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

**Element 29 — Grant Date**

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

**Element 30 — Expiration Date**

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

**Element 31 — 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 32 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 33 — Date Signed**

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

**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.