

FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTIEMETICS, CANNABINOIDS 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 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 items. 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 Antiemetics, Cannabinoids, F-00194. Pharmacy providers are required to use the PA/PDL for Antiemetics, Cannabinoids 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/.
- 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 Antiemetics, Cannabinoids form.

For PA requests for dronabinol, providers are required to complete Section III, Section III A or Section III B, and Section VI on the PA/PDL for Antiemetics, Cannabinoids form and submit the request to ForwardHealth on the ForwardHealth Portal or on paper by mail or fax. Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol[®]. Additional documentation should be included in Section VI or submitted as an attachment.

Element 12 — 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 diagnosis description.

SECTION III A — CLINICAL INFORMATION FOR MARINOL[®] ONLY

Element 13

Check the appropriate box to indicate whether or not the member has been diagnosed with a loss of appetite/weight loss caused by Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome. If yes, providers do not need to complete Section III B.

SECTION III B — CLINICAL INFORMATION FOR MARINOL[®] AND CESAMET

Element 14

Check the appropriate box to indicate whether or not the member has experienced a treatment failure with ondansetron for chemotherapy-related nausea and vomiting.

Element 15

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

Element 16

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

Element 17

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction while taking ondansetron. If yes, describe the clinically significant adverse drug reaction in the space provided.

Element 18

Check the appropriate box to indicate whether or not the member has experienced a treatment failure with Emend® for chemotherapy-related nausea and vomiting.

Element 19

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

Element 20

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and Emend®. If yes, describe the clinically significant drug interaction in the space provided.

Element 21

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction while taking Emend®. If yes, describe the clinically significant adverse drug reaction in the space provided.

SECTION III C — CLINICAL INFORMATION FOR CESAMET ONLY

For PA requests for Cesamet, providers should complete Section III B and Section III C.

Element 22

Check the appropriate box to indicate whether or not the member has experienced a treatment failure with Marinol® for chemotherapy-related nausea and vomiting.

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.

Note: ForwardHealth will not approve a days' supply greater than 183 days.

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 product requested may be included here.