

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SINGULAIR® 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.

Attach the completed Prior Authorization Drug Attachment for Singulair® form, F-00204, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Note: The only strength of Singulair® for which PA may be requested is Singulair® 10 mg.

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

This element is populated with Singulair®.

Element 5 — Drug Strength

This element is populated with 10 mg.

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 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

This section must be completed for all requests for Singulair®.

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.

Element 14

Indicate whether or not the member has tried loratadine and experienced an adverse drug reaction or tried loratadine for at least one week and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates loratadine was taken in the space provided.

Element 15

Indicate whether or not the member has tried cetirizine and experienced an adverse drug reaction or tried cetirizine for at least one week and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates cetirizine was taken in the space provided.

Element 16

Indicate whether or not the member has tried fluticasone and experienced an adverse drug reaction or tried fluticasone for at least two weeks and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates fluticasone was taken in the space provided.

Element 17

Indicate whether or not the member tried flunisolide and experienced an adverse drug reaction or tried flunisolide for at least two weeks and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates flunisolide was taken in the space provided.

Element 18

Indicate whether or not the member has taken loratadine or cetirizine in combination with fluticasone or flunisolide for at least two weeks and experienced a treatment failure. If yes, list the drugs involved, the specific details about the treatment failure, and the approximate dates the drugs were taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

The physician must read and sign the attestation statement for consideration of the PA request.

Element 19 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 20 — Date Signed

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

SECTION V — ADDITIONAL INFORMATION

Element 21

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