FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ULCERATIVE COLITIS 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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stats. § 49.45(4), 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. Prescribers and pharmacy providers 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis, F-00694. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Ulcerative Colitis 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, by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Pharmacy 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, pharmacy providers may access *www.forwardhealth.wi.gov/.*

3) For PA requests submitted 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 PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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 prescribing provider's National Provider Identifier (NPI) for prescriptions for non-controlled substances.

Element 10 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescribing provider.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the prescriber.

SECTION III — CLINICAL INFORMATION FOR ULCERATIVE COLITIS

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for CAM Antagonist Drugs for Ulcerative Colitis.

Element 12 — Diagnosis Code and Description
Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

Element 13
Check the appropriate box to indicate whether or not the member has a diagnosis of ulcerative colitis.

Element 14
Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of ulcerative colitis.

Element 15
Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

Element 16
Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member is currently using Humira® for ulcerative colitis. If yes, complete Section IIIA of the form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING HUMIRA® FOR ULCERATIVE COLITIS

Element 18
Check the appropriate box to indicate whether or not the member has been using Humira® for ulcerative colitis for at least the past two months.

Element 19
Check the appropriate box to indicate whether or not the member has shown evidence of clinical remission since starting Humira®.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

Element 20
Check the appropriate box to indicate whether or not the member has taken a preferred cytokine and CAM antagonist drug for at least **two** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the preferred cytokine and CAM antagonist drug taken, including dose, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 21 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 22 — 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 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 request 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 PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 32
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.