FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS 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 service.

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 Drug Attachment for Anti-obesity Drugs form, F-00163, to request PA for anti-obesity drugs. Prescribers are required to retain a completed copy of the form.

Prescribers may submit PA requests on a PA drug attachment form in one of the following ways:

1) For requests submitted through the Drug Authorization and Policy Override Center, prescribers may call (800) 947-9627.

2) For requests submitted on the ForwardHealth Portal, prescribers may access *www.forwardhealth.wi.gov/.*

3) For PA requests submitted by fax, prescribers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment form to ForwardHealth at (608) 221-8616.

4) For PA requests submitted by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

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).

SECTION I — MEMBER AND PROVIDER 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.

Element 4 — Name — Prescriber
Enter the name of the prescriber.

Element 5 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 6 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 8 — Name — Billing Provider
Enter the name of the billing provider. Prescribers should indicate their name and NPI as the billing provider on the PA request.

Element 9 — NPI — Billing Provider
Enter the 10-digit NPI of the billing provider.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name
Enter the drug name.

Element 11 — Drug Strength
Enter the strength of the drug listed in Element 10.

Element 12 — Date Prescription Written
Enter the date the prescription was written.

Element 13 — Directions for Use
Enter the directions for use of the drug.

Element 14 — Refills
Enter the number of refills.

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Anti-obesity Drugs form.

Element 15 — 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 16 — Height — Member
Enter the member's height in inches.

Element 17 — Weight — Member
Enter the member's weight in pounds.

Element 18 — Date Member's Weight Was Measured
Enter the date the member's weight was measured in MM/DD/CCYY format.

Element 19 — Body Mass Index (BMI) — Member
Enter the member's current body mass index (BMI) using the following equation.

$$\text{BMI} = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$$

Example: Height = 5'9"
Weight = 230 lbs
Figure out height in inches: 5 x 12 = 60 + 9 = 69

$$\text{BMI} = \frac{703 \times 230}{69^2} \qquad \text{BMI} = \frac{161690}{4761} \qquad \text{BMI} = 33.96$$

Element 20 — Goal Weight — Member
Enter the member's goal weight in pounds. This should be a number agreed upon by the prescribing medical practitioner and the member.

SECTION IIIA — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

For an initial drug request, the prescriber should complete Sections IIIA and IIIB. For a renewal drug request, the prescriber should complete Section IIIA.

Element 21
Check the appropriate box to indicate whether or not the member is pregnant or nursing.

Element 22
Check the appropriate box to indicate whether or not the member has a history of an eating disorder (e.g., anorexia, bulimia).

Element 23
Check the appropriate box to indicate whether or not the prescriber has evaluated and determined the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.

Element 24
Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse.

SECTION IIIB — INITIAL COVERAGE REQUIREMENTS

Complete this section for initial requests for anti-obesity drugs.

Element 25 — BMI Requirements
Check the appropriate box to indicate whether or not the member's BMI is greater than or equal to 30 or greater than or equal to 27 but less than 30 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, or type II diabetes mellitus. If applicable, indicate the member's current risk factors.

Element 26
Check the appropriate box to indicate whether or not the member has participated in a weight loss treatment plan in the past six months and if the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 27 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 28 — Date Signed — Prescriber
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 29
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.