FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS 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 PA for certain drugs. Refer to the Pharmacy service area of the ForwardHealth Online Handbook 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 Glucagon-Like Peptide (GLP-1) Agents, F-00238, to request PA for GLP-1 agents. Pharmacy providers are required to use the PA/PDL for GLP-1 Agents 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.

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/.*

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 Wisconsin's 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 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

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL GLP-1 Agents form.

Element 13 — Diagnosis Code and Description
Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the drug or biologic requested. The ICD diagnosis code must correspond with the ICD description. The diagnosis code indicated must be an allowable diagnosis code for GLP-1 agents.

Element 14
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the member is currently receiving long-acting insulin injections (e.g., Lantus, Levemir®.

Element 16
Check the appropriate box to indicate whether or not the member is currently receiving rapid-acting or short-acting insulin injections.

Element 17
Check the appropriate box to indicate whether or not the member is currently receiving intermediate-acting or premixed insulin injections.

Element 18
Check the appropriate box to indicate whether or not the member currently has or is there a history of pancreatitis.

Element 19
Check the appropriate box to indicate whether or not the member currently has or is there a history of gastroparesis.

Element 20
Check the appropriate box to indicate whether or not the member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.

Element 21
Indicate the member's most current hemoglobin (HbA1c). In the STAT-PA system, indicate the member's most current HbA1c as a three-digit number (e.g., if the member's most current HbA1c is 5.6 percent, enter "056").

Element 22
Indicate the date the member's most current HbA1c was measured in MM/DD/CCYY format. The member's most current HbA1c measurement must be within the past six months.

Element 23
Check the appropriate box to indicate whether or not the member has been taking the maximum dose of metformin (1,700 mg/day to 2,500 mg/day) for the past three months.

Element 24
Check the appropriate box to indicate whether or not the member is currently taking and will continue to take the maximum effective dose of metformin.

Element 25
Check the appropriate box to indicate whether or not the member is unable to take the maximum effective dose of metformin. If yes is checked, list the reason(s) why the member is not taking the maximum effective dose of metformin in the space provided.

Element 26
Check the appropriate box to indicate whether or not the member is currently using a GLP-1 agent. If yes is checked, also complete Section IIIA of the PA/PDL for GLP-1 Agents form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING A GLP-1 AGENT

Element 27
Check the appropriate box to indicate whether or not the member has been using a GLP-1 agent for the past six months.

Element 28
Check the appropriate box to indicate whether or not the member's most current HbA1c has decreased by at least 0.5 percent since starting a GLP-1 agent.

Element 29
Check the appropriate box to indicate whether or not the member's HbA1c has dropped below seven percent since starting a GLP-1 agent.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED GLP-1 AGENTS ONLY

Complete this section only for PA requests for non-preferred GLP-1 agents. Prior authorization requests for non-preferred GLP-1 agents must be submitted on paper.

Element 30
Check the appropriate box to indicate whether or not the member has taken the maximum dose of Byetta for at least three consecutive months in the last year and failed to achieve at least a 0.5 percent decrease in HbA1c. If yes is checked, list the dates Byetta was taken, the dose of Byetta, and directions for use. In addition, list the member's HbA1c values prior to starting Byetta, the member's HbA1C values during treatment with Byetta, and the dates the values were measured in the space provided.

Element 31
Check the appropriate box to indicate whether or not the member has taken Byetta in the last year and experienced a clinically significant adverse drug reaction. If yes is checked, list the dates Byetta was taken, the dose of Byetta, directions for use, and specific details about the clinically significant adverse drug reaction in the space provided.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 32 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 33 — Days' Supply Requested
Enter the requested days' supply.

Element 34 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider taxonomy code is not 333600000X.

Element 35 — 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 36 — 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 37 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 38 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 39 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 40 — 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 41 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 42 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 43
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.