FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR DIABETIC SUPPLIES 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.

Prior authorization requests for diabetic supplies submitted on paper require the use of this form. 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 Diabetic Supplies form, F-00239, to request PA for diabetic supplies. 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 on the ForwardHealth Portal, providers may access *www.forwardhealth.wi.gov/.*

2) For paper PA requests 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.

3) For paper PA requests by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment form 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 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.

Element 3— Date of Birth
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 — Name — Prescriber
Enter the name of the prescriber.

Element 5 — Prescriber National Provider Identifier
Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

Element 6 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 7 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — DIABETIC SUPPLY INFORMATION

Element 8 — Name of Non-preferred Meter
Enter the name of the non-preferred blood glucose testing meter.

Element 9 — Name of Non-preferred Test Strips
Enter the name of the non-preferred blood glucose test strips.

SECTION IV — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 15, check "yes" to all that apply.

Element 10 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 11
Indicate whether or not the member has Type I diabetes.

Element 12
Indicate whether or not the member has Type II diabetes.

Element 13
Indicate whether or not the member has gestational diabetes.

Element 14
Indicate whether or not the member is using an insulin pump. If yes, indicate the manufacturer or type of insulin pump.

Element 15
Indicate whether or not the member is using a continuous glucose monitoring system. If yes, indicate the manufacturer or type of continuous glucose monitoring system.

Element 16
Indicate whether or not the member has a medical condition that requires the use of a specialized meter. If yes, indicate the condition.

Element 17
Indicate whether or not the member has tried and failed on a product from each of the preferred manufacturers. If yes, indicate each product name, the dates of use, and the reason for failure.

Element 18
Indicate whether or not the member has a medical condition that prevents the use of a preferred manufacturer. If yes, indicate why the member cannot use the preferred manufacturer.

SECTION V — AUTHORIZED SIGNATURE

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 Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075, was signed (in MM/DD/CCYY format).

SECTION VI — ADDITIONAL INFORMATION

Element 21
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.