

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BLOOD GLUCOSE METERS AND TEST STRIPS 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 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 Blood Glucose Meters and Test Strips, F-00239. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips form to request PA for blood glucose meters and test strips 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 drug attachment form in one of the following ways:

- 1) For requests submitted on the ForwardHealth Portal, pharmacy providers may access www.forwardhealth.wi.gov/.
- 2) For PA requests submitted by fax, pharmacy providers 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 PA requests submitted by mail, pharmacy providers 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

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

Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Product Name

Enter the product name.

Element 5 — Date Prescription Written

Enter the date the prescription was written.

Element 6 — Refills

Enter the number of refills.

Element 7 — Directions for Use

Enter the directions for use of the product.

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 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 prescribing provider.

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips.

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 is using an insulin pump. If yes, indicate the manufacturer or type of insulin pump.

Element 14

Check the appropriate box to indicate whether or not the member has a medical condition that requires the use of a specialized meter (e.g., visually impaired). If yes, indicate the medical condition that requires the use of a specialized meter.

Element 15

Check the appropriate box to indicate whether or not the member is unable to use a product from each of the preferred manufacturers. If yes, specifically address why the member is unable to use a product from each of the preferred manufacturers. Documentation of previous preferred products attempted and detailed reasons why they were discontinued or unable to be used is required.

SECTION IV — AUTHORIZED SIGNATURE

Element 16 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 17 — Date Signed

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

SECTION V — ADDITIONAL INFORMATION

Element 18

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