

## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ZETIA OR VYTORIN 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 services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the Pharmacy page of the ForwardHealth Online Handbook for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a determination about the request.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Zetia or Vytarin, F-00279. Pharmacy providers are required to use the PA/PDL for Zetia or Vytarin 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 or on paper. 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/](http://www.forwardhealth.wi.gov/).
- 3) For paper PA requests 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 paper PA requests 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

#### 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 for Zetia or Vytorin form.

**Element 13 — 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 14**

Check the box to indicate whether or not the member is being treated for an elevated total cholesterol level.

**Element 15**

Check the box to indicate whether or not the member is being treated for an elevated low-density lipoprotein cholesterol level.

**SECTION IIIA — CLINICAL INFORMATION FOR ZETIA**

**Element 16**

Check the box to indicate whether or not the member has a medical condition(s) or contraindication(s) that prevents him or her from taking a 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitor (i.e., statin) drug. If yes, list the medical condition(s) or contraindication(s) in the space provided.

**Element 17**

Check the box to indicate whether or not there is a clinically significant drug interaction with another medication the member is taking and a statin drug. If yes, list the medication(s) and interaction(s) in the space provided.

**Element 18**

Check the box to indicate whether or not the member is currently taking or has previously taken a statin drug.

**Element 19**

Check the box to indicate whether or not the member experienced a clinically significant adverse drug reaction to a statin drug. If yes, list the name of the drug, specific details about the clinically significant adverse drug reaction, and the approximate dates of the adverse drug reaction in the space provided.

**Element 20**

Check the box to indicate whether or not the member has taken a preferred statin drug for at least three consecutive months and experienced an unsatisfactory therapeutic response. If yes, list the name of the drug, dose of the drug, and the approximate dates the drug was taken in the space provided.

**SECTION IIIB — CLINICAL INFORMATION FOR VYTORIN**

**Element 21**

Check the box to indicate whether or not the member is stabilized on Vytorin and achieving a measureable therapeutic response.

**Element 22**

Check the box to indicate whether or not the member is stabilized on simvastatin plus Zetia as two separate drugs and achieving a measureable therapeutic response.

**Element 23**

Check the box to indicate whether or not the member has a medical condition(s) that prevents him or her from taking simvastatin plus Zetia as two separate drugs. If yes, list the medical condition(s) in the space provided.

**Element 24**

Check the box to indicate whether or not member preference or member copayment are reasons why the member is unable to take simvastatin plus Zetia as two separate drugs.

**SECTION IV — AUTHORIZED SIGNATURE**

**Element 25 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 26 — 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 27 — National Drug Code**

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

**Element 28 — Days' Supply Requested**

Enter the requested days' supply.

**Element 29 — NPI**

Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

**Element 30 — 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 31 — 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 32 — Assigned PA Number**

Enter the PA number assigned by the STAT-PA system.

**Element 33 — Grant Date**

Enter the date the PA was approved by the STAT-PA system.

**Element 34 — Expiration Date**

Enter the date the PA expires as assigned by the STAT-PA system.

**Element 35 — Number of Days Approved**

Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION VI — ADDITIONAL INFORMATION**

**Element 36**

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