DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00556A (07/12)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTIPSYCHOTIC DRUGS FOR CHILDREN 6 YEARS OF AGE AND YOUNGER COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information also applies to Medicaid.

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 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 Antipsychotic Drugs for Children 6 Years of Age and Younger, F-00556. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger 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 drug attachment 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, pharmacy providers can access *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 Attachment to ForwardHealth at (608) 221-8616.

4) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA 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 — Member
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 — Drug Name
Enter the drug name.

Element 5 — Drug Strength
Enter the strength of the drug listed in Element 4.

Element 6 — National Drug Code (NDC)
Enter the National Drug Code (NDC) of the drug prescribed.

Element 7 — Date Prescription Written
Enter the date the prescription was written.

Element 8 — Directions for Use
Enter the directions for use of the drug.

Element 9 — Start Date Requested
Enter the requested start date.

Element 10 — Name — Prescriber
Enter the name of the prescriber.

Element 11 — National Provider Identifier (NPI)
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 12 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 13a — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 13b
In case the PA consultant needs additional information about the member, provide a contact person and telephone number at the clinic where the member was seen that can be contacted to discuss the member's clinical information.

SECTION III — Diagnosis and Weight Information

Element 14 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and the description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 15a — Body Mass Index — Member
Indicate the member's current body mass index (BMI) using the following equation. Indicate the member's most current BMI as a three-digit number (e.g., if the member's BMI is 33, enter 33.0).

Refer to the formula below or to the BMI calculator on the Centers for Disease Control and Prevention Web site at *http://apps.nccd.cdc.gov/dnpabmi/.*

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

Example: Height = 5'9"
Weight = 230 lbs
Figure out height in inches: 5x12 = 60 + 9 = 69

$$\text{BMI} = \frac{703 \times 230}{69^2} \qquad \text{BMI} = \frac{161690}{4761} \qquad \text{BMI} = 33.9$$

Element 15b — Date Weight and Height Measured
Enter the date the member's height and weight were measured in MM/CCYY format.

SECTION IV — PRESCRIBER SPECIALTY INFORMATION

Element 16
Check the appropriate box(es) to indicate the prescriber's medical/nursing specialty. If other, specify the medical/nursing specialty in the space provided.

SECTION V — CLINICAL INFORMATION

Element 17
Indicate, to the best of your knowledge, whether or not the child and/or family have been involved with at least one of the listed mental health resources within the past year. If yes, check all the mental health resource(s) that apply. If other, indicate the other mental health resource(s) in the space provided.

Element 18
Indicate whether or not the member is in foster care.

Element 19
Check the appropriate box to indicate the child's *one* primary target symptom. If other, specify the target symptoms in the space provided.

SECTION VI — DRUG INFORMATION

Element 20
Indicate whether or not the child is currently taking psychoactive medication(s) (other than the drug requested). If yes, check the medication category(s) and indicate the name of the drug(s) and total daily dose on each line. Check all categories that apply.

Element 21
Indicate whether or not the child has previously (within the last 12 months) taken a psychoactive medication(s) that he or she is no longer taking. If yes, check the medication category(s), and indicate the name of the drug(s) on each line provided. Check all categories that apply.

SECTION VII — CLINICAL INFORMATION FOR A NON-PREFERRED DRUG

Element 22
If the drug being requested is a non-preferred drug on the ForwardHealth Preferred Drug List, indicate the preferred drugs that have been attempted in the past. Also, include clinical justification why a non-preferred drug is necessary over a preferred drug.

SECTION VIII — FOR PHARMACY PROVIDERS USING STAT-PA

Element 23 — NDC
Enter the appropriate 11-digit NDC for each drug.

Element 24 — Days' Supply Requested
Enter the requested days' supply.

Element 25 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider taxonomy code is not 333600000X.

Element 26 — 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 27 — 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 28 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 29 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 30 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

SECTION IX — AUTHORIZED SIGNATURE

Element 31 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 32 — Date Signed
Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION X — ADDITIONAL INFORMATION

Element 33
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.