FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MIGRAINE AGENTS, INJECTABLE 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 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 Migraine Agents, Injectable, F-00622. Pharmacy providers are required to use the PA/PDL for Migraine Agents, Injectable 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/.*

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 Migraine Agents, Injectable 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 requested. The ICD diagnosis code must correspond with the ICD description.

Element 14
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to an oral sumatriptan product. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the oral sumatriptan product was taken in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents him or her from using an oral sumatriptan product. If yes is checked, list the medical condition(s) in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to a nasal sumatriptan product. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the nasal sumatriptan product was used in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents him or her from using a nasal sumatriptan product. If yes is checked, list the medical condition(s) in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member has used a preferred injectable sumatriptan product and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes is checked, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred injectable sumatriptan product was used in the space provided.

Element 19
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents him or her from using a preferred injectable sumatriptan product. If yes is checked, indicate the medical condition(s) in the space provided.

Element 20
Check the appropriate box to indicate whether or not member preference is the reason why the member is unable to use a preferred injectable sumatriptan product.

SECTION IV — AUTHORIZED SIGNATURE

Element 21 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 22 — 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 23 — National Drug Code
Enter the appropriate 11-digit National Drug Code 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's 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.

Element 31 — 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 32
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.