DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00806A (07/13)

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

FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR ANTICOAGULANTS, ORAL 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 Anticoagulants, Oral form, F-00806. Pharmacy providers are required to use the PA/PDL for Anticoagulants, Oral 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted 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 Anticoagulants, Oral 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 appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Pradaxa®. If yes is checked, list the dates Pradaxa® was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 15
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Pradaxa®. If yes is checked, list the drug(s) and interaction(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 with Xarelto®. If yes is checked, list the dates Xarelto® was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 17
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Xarelto®. If yes is checked, list the drug(s) and interaction(s) in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — 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 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply.

Element 22 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 23 — 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 24 — 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 25 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 27 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 28 — 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 29
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.