

## FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SOVALDI™ 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 Sovaldi™, F-01247. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Sovaldi™ form to request PA 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 drug attachment form in one of the following ways:

- 1) For requests submitted on the ForwardHealth Portal, providers can access [www.forwardhealth.wi.gov/](http://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 attachment to ForwardHealth at (608) 221-8616.
- 3) For PA requests 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 — Member

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

## SECTION II — PRESCRIPTION INFORMATION

### Element 4 — Date Prescription Written

Enter the date the prescription was written.

### Element 5 — Directions for Use

Enter the directions for use of the drug.

### Element 6 — Refills

Enter the number of refills.

### Element 7 — Name — Prescriber

Enter the name of the prescribing provider.

### Element 8 — National Provider Identifier — Prescriber

Enter the prescribing provider's 10-digit National Provider Identifier.

### Element 9 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

### Element 10 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

## SECTION III — CLINICAL INFORMATION

### Element 11 — 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 12 — Date Member Was Diagnosed with Hepatitis C

Enter the date (in MM/DD/CCYY format) that the member was diagnosed with hepatitis C.

### Element 13

Indicate the member's hepatitis C virus (HCV) Genotype and subtype in the space provided.

### Element 14

Check the appropriate box to indicate whether or not the member is 18 years of age or older.

### Element 15

Check the appropriate box to indicate whether or not the member is pregnant.

### Element 16

Check the appropriate box to indicate whether or not the member has had a liver transplant.

### Element 17

Check the appropriate box to indicate whether or not the member is on a liver transplant wait list.

### Element 18

Check the appropriate box to indicate whether or not the member has hepatocellular carcinoma.

### Element 19

Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was taken in the spaces provided.

### Element 20

Indicate the drug name, daily dose, and expected duration for the proposed hepatitis C drug treatment regimen. Indicate whether or not the member is currently taking the drug. If the member is currently taking this drug, enter the date started.

### Element 21

Indicate the drug name, daily dose, and dates taken for the member's previous hepatitis C drug therapy. Check "None" if appropriate.

### Element 22

List the drug name for all non-hepatitis C drugs the member is currently receiving. Check "None" if appropriate.

**Element 23**

Check the appropriate box to indicate whether or not the member has a history of alcohol abuse or illicit drug use. If yes, provide details.

**Element 24**

If the member has a history of alcohol abuse or illicit drug use, enter the date that he or she last participated in alcohol abuse or illicit drug use. Provide documentation of at least six months of abstinence from alcohol abuse or illicit drug use.

**Element 25**

If the member has a history of alcohol abuse or illicit drug use, Check the appropriate box to indicate whether or not he or she is currently participating in a recovery program, including counseling services, or addiction specialist and toxicology screening. If yes, provide details.

**Element 26**

Check the appropriate box to indicate whether or not the member has had a liver biopsy. If yes, list the date taken.

*Note:* A copy of the results needs to be submitted with the PA request.

**Element 27**

Check the appropriate box to indicate whether or not the member has had a liver ultrasound or scan. If yes, list the date taken.

*Note:* A copy of the results needs to be submitted with the PA request.

**Element 28**

If a Metavir score was calculated, provide the score, or write "None" if appropriate.

Metavir Scores

0 = No scarring.

1 = Minimal scarring.

2 = Scarring has occurred and extends outside the areas in the liver that contains blood vessels.

3 = Bridging fibrosis is spreading and connecting to other areas that contain fibrosis.

4 = Cirrhosis or advanced scarring of the liver.

**Element 29**

Check the appropriate box to indicate whether or not the member has cirrhosis of the liver. If yes, Check the appropriate box to indicate whether or not the cirrhosis is compensated, and enter the member's most recent Child-Turcotte-Pugh Score.

**Element 30**

Check the appropriate box to indicate whether or not the member is coinfecting with hepatitis A, hepatitis B, or Human Immunodeficiency Virus. If yes, list the member's coinfection(s).

**Element 31**

Check the appropriate box to indicate whether or not the member is a candidate for treatment with interferon alfa. If no, explain why the member is unable to take interferon alfa.

**SECTION IV — AUTHORIZED SIGNATURE**

**Element 32 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 33 — Date Signed**

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

**SECTION V — ADDITIONAL INFORMATION**

**Element 34**

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