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/.*

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
A copy of the current medical records needs to be submitted with the PA request, including the following:

- Hepatitis C virus (HCV) assessment and treatment plan, including psychosocial history.
- Assessment of other significant or uncontrolled diseases, including complete problem list.
- Complete medication list.
- Lab data: Liver function tests, complete blood count, serum creatinine, albumin, international normalized ratio.

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 likely source of the HCV infection in the space provided.

Element 14
Indicate the member's HCV Genotype and subtype in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 16
Check the appropriate box to indicate whether or not the member is pregnant.

Element 17
Check the appropriate box to indicate whether or not the member has had a liver transplant.

Element 18
Check the appropriate box to indicate whether or not the member is on a liver transplant wait list.

Element 19
Check the appropriate box to indicate whether or not the member has hepatocellular carcinoma.

Element 20
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 21
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 22
Indicate the drug name, daily dose, and dates taken for the member's previous hepatitis C drug therapy. Check "None" if appropriate.

Element 23
List the drug name for all non-hepatitis C drugs the member is currently receiving. Check "None" if appropriate.

Element 24
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 25
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 26
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 27
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 must be submitted with the PA request.

Element 28
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 must be submitted with the PA request.

Element 29
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 contain blood vessels.
3 = Bridging fibrosis is spreading and connecting to other areas that contain fibrosis.
4 = Cirrhosis or advanced scarring of the liver.

Element 30
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.

Note: A copy of the clinical documentation that indicates the member is compensated, including physical exam findings, must be submitted with the PA request.

Element 31
Check the appropriate box to indicate whether or not the member is coinfected with hepatitis A, hepatitis B, or Human Immunodeficiency Virus. If yes, list the member's coinfection(s).

Element 32
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.

Note: If mental health conditions are the basis for the member being unable to take interferon alfa, documentation from the member's mental health provider must be submitted with the PA request.

SECTION IV — AUTHORIZED SIGNATURE

Element 33 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 34 — Date Signed
Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 35
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.