FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS RENEWAL 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 (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 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 Hepatitis C Agents Renewal, F-01248. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Hepatitis C Agents Renewal 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, pharmacy providers can access *www.forwardhealth.wi.gov/.*

2) For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Amendment Request, F-11042, and the appropriate PA attachment to ForwardHealth at 608-221-8616.

3) For PA requests by mail, pharmacy providers should submit a Prior Authorization Amendment Request 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
Indicate the drug name, daily dose, and expected duration for the member's complete hepatitis C drug treatment regimen.

Element 5 — Name — Prescriber
Enter the name of the prescriber.

Element 6 — National Provider Identifier — Prescriber
Enter the prescriber's 10-digit National Provider Identifier.

Element 7 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 8 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION FOR RENEWAL
Note: **A copy of the member's hepatitis C virus ribonucleic acid (HCV-RNA) level lab results must be submitted with each renewal request.**

Element 9 — Approved PA Number
Enter the PA number assigned on the initial approved PA request.

Element 10 — Date Member Began Therapy
Enter the date (in MM/DD/CCYY format) that the member began therapy.

Element 11
Indicate the member's HCV-RNA level at treatment **week 4** and the date it was taken in the spaces provided.

Element 12
Indicate the member's HCV-RNA level at treatment **week 12** and the date it was taken in the spaces provided.

Element 13
If additional HCV-RNA levels were drawn, indicate the treatment week, the member's HCV-RNA level, and the date it was taken in the spaces provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 14 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 15 — Date Signed
Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 16
Include any additional information in the space provided, including additional diagnostic and clinical information explaining the need for the drug requested may be included here.