# FORWARDHEALTH
# PRIOR AUTHORIZATION DRUG ATTACHMENT FOR XYREM®
# 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 a PA for certain drugs. If necessary, attach additional pages if more space is needed. 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 Xyrem®, F-01430. Pharmacy providers are required to use the Prior Authorization/Drug Attachment for Xyrem® form to request PA for Xyrem® 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.

Pharmacy 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 may 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 drug attachment form to ForwardHealth at (608) 221-8616.

3) For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA drug attachment 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
Providers should check only the name and strength of the drug for which PA is being requested.

**Element 4 — Drug Name**
Enter the name of the drug.

**Element 5 — Drug Strength**
Enter the strength of the drug in milligrams.

**Element 6 — Date Prescription Written**
Enter the date that the prescription was written.

**Element 7 — Directions for Use**
Enter the directions for use of the drug.

**Element 8 — Refills**
Enter the number of refills.

**Element 9 — Name — Prescriber**
Enter the name of the prescriber.

**Element 10 — National Provider Identifier — Prescriber**
Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

**Element 11 — Address — Prescriber**
Enter the address (street, city, state, and ZIP+4 code) of the prescribing provider.

**Element 12 — Telephone Number — Prescriber**
Enter the telephone number, including area code, of the prescribing provider.

**SECTION III — CLINICAL INFORMATION**
*Note:* A copy of the current medical records that support the member's condition of narcolepsy with cataplexy or narcolepsy without cataplexy needs to be submitted with the PA request, including the following:

- Results from the polysomnogram (PSG) and multiple sleep latency test (MSLT), along with provider interpretation.
- For members with excessive daytime sleepiness (EDS), a copy of the Epworth sleepiness scale (ESS) questionnaire, maintenance of wakefulness test (MWT), or MSLT.
- For renewal requests, medical records must demonstrate clinical improvement, including a decrease in cataplexy or a decrease in the member's daytime sleepiness, supported by an ESS, MWT, or MSLT.

**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 narcolepsy with cataplexy.

**Element 15**
Check the appropriate box to indicate whether or not the member has narcolepsy without cataplexy.

**Element 16**
Check the appropriate box to indicate whether or not the member is 16 years of age or older.

**Element 17**
Check the appropriate box to indicate whether or not the member has a succinic semialdehyde dehydrogenase deficiency.

**Element 18**
Check the appropriate box to indicate whether or not the member has a documented history of abstinence from alcohol for at least the past six months.

**Element 19**
Check the appropriate box to indicate whether or not the member has a history of substance abuse, addiction, or diversion.

**Element 20**
Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

**Element 21**
Check the appropriate box to indicate whether or not the member is taking central nervous system (CNS) depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact his or her daytime sleepiness. If yes, indicate the CNS depressants and daily doses in the spaces provided.

**Element 22**
Check the appropriate box to indicate whether or not the member has had an overnight PSG sleep study followed by an MSLT.

**Element 23**
Check the appropriate box to indicate whether or not the member has EDS that interferes with normal activities on a daily basis.

**Element 24**
Check the appropriate box to indicate whether or not the member completed an ESS questionnaire, MWT, or MSLT.

**Element 25**
Check the appropriate box to indicate whether or not the prescriber has ruled out or treated the member for each of the following potential causes of EDS:

- Other sleep disorders including sleep apnea.
- Chronic pain or illness that disrupts normal sleep patterns.
- Mood disorders such as depression.
- Caffeine or nicotine use causing poor quality of nighttime sleep.

**Element 26**
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 a stimulant. If yes, list the stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the stimulant was taken in the space provided.

**Element 27**
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of a stimulant. If yes, list the medical condition(s) that prevents the use of a stimulant in the space provided.

**Element 28**
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and stimulants. If yes, list the medication(s) and interaction(s) in the space provided.

**Element 29**
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response after the medication has been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with modafinil or Nuvigil®. If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates modafinil or Nuvigil® were taken in the space provided.

**Element 30**
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of modafinil or Nuvigil®. If yes, list the medical condition(s) that prevents the use of modafinil or Nuvigil® in the space provided.

**Element 31**
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and modafinil or Nuvigil®. If yes, list the medication(s) and interaction(s) in the space provided.

**Element 32**
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or serotonin norepinephrine reuptake inhibitor (SNRI). If yes, list the TCA, SSRI, or SNRI and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the TCA, SSRI, or SNRI was taken in the space provided.

## SECTION IV — AUTHORIZED SIGNATURE

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

**Element 34 — Date Signed**
Enter 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 here.