FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR OPIOID DEPENDENCY AGENTS – BUPRENORPHINE 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. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 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 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/Preferred Drug List (PA/PDL) for Opioid Dependency Agents – Buprenorphine, F-00081. Pharmacy providers are required to use the PA/PDL for Opioid Dependency Agents 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, pharmacy 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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. 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 ID card and the EVS do not match, use the spelling from the EVS.

Element 2 – Member ID 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 prescribed drug.

Element 5 – Drug Strength
Check the appropriate box to indicate the strength(s) of the drug prescribed in milligrams.

Element 6 – Date Prescription Written
Enter the date that 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 Opioid Dependency Agents form.

Element 13 – Diagnosis Code and Description
Enter the appropriate *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. The diagnosis code indicated must be an allowable diagnosis code for opioid dependency agents.

Element 14
Check the appropriate box to indicate whether or not the member is 16 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the prescriber has a valid Drug Addiction Treatment Act of 2000 (DATA 2000) waiver. If yes is checked, indicate the prescriber's "X" Drug Enforcement Administration (DEA) number in the space provided. Check no if the prescriber does not participate in this program.

Element 16
Check the appropriate box to indicate whether or not the prescriber has read the educational brochure titled "Office-Based Buprenorphine Therapy for Opioid Dependence: Important Information for Prescribers" provided through the Buprenorphine-containing Transmucosal products for Opioid Dependence (BTOD) Risk Evaluation and Mitigations Strategy (REMS) program. If yes is checked, indicate whether or not the prescriber has communicated the key messages to the member about the risks of accidental overdose, misuse, and abuse while taking products covered under the BTOD REMS program.

Element 17
Check the appropriate box to indicate whether or not the member is taking any other opioids, tramadol, or carisoprodol. If yes is checked, list the drug(s) taken and the dates they have been taken in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member has been receiving BTOD treatment for greater than two years. If yes, indicate whether or not the member is being maintained on a daily dose of 12 mg or less of BTOD.

Element 19
Check the appropriate box to indicate whether or not the member is taking any benzodiazepines. If yes, indicate whether or not the prescriber of the BTOD is also the prescriber of the benzodiazepines.

Element 20
Check the appropriate box to indicate whether or not the member is pregnant.

SECTION IV – ATTESTATION
The physician is required to read and sign the attestation statement for consideration of the PA request.

Element 21
Check the appropriate box to indicate whether or not the prescriber has read the attestation statement.

Element 22
Check the appropriate box to indicate whether or not the prescriber agrees to follow the guidelines set forth by State Medical Boards for opioid addiction treatment.

SECTION V – ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE TABLET REQUESTS
This section must be completed for pregnant women only.

Element 23
Indicate the member's expected delivery date in MM/DD/CCYY format.

Element 24
Check the appropriate box to indicate whether or not the prescriber has discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant women.

Element 25
Check the appropriate box to indicate whether or not the prescriber has informed the member about the limited safety data for the support of buprenorphine use in pregnant women.

SECTION VI – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED BUPRENORPHINE-NALOXONE DRUG REQUESTS
Prior authorization requests for non-preferred buprenorphine-naloxone drugs must be submitted on paper.

Element 26
Provide detailed clinical justification for prescribing a non-preferred buprenorphine-naloxone drug instead of Suboxone® film and Zubsolv®, including clinical information why the member cannot use Suboxone® film and Zubsolv® and why it is medically necessary that the member receive a non-preferred buprenorphine-naloxone drug instead of Suboxone® film and Zubsolv® in the space provided.

SECTION VII – AUTHORIZED SIGNATURE

Element 27 – Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 28 – Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VIII – FOR PHARMACY PROVIDERS USING STAT-PA

Element 29 – National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 30 – Days' Supply Requested
Enter the requested days' supply.

Note: ForwardHealth will not approve a days' supply greater than 183 days.

Element 31 – NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 32 – 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 33 – 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 34 – Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 35 – Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 36 – Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 37 – Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION IX – ADDITIONAL INFORMATION

Element 38
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.