FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, OMEGA-3 ACIDS 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 (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 service.

Prior authorization requests for Lipotropics, Omega-3 Acids submitted by fax or by mail require the use of this form. 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 Lipotropics, Omega-3 Acids form, F-00162, to request PA for Lipotropics, Omega-3 Acids. Prescribers are required to retain a completed copy of the form.

Prescribers may submit PA requests on a PA drug attachment form in one of the following ways:

1) For requests submitted through the Drug Authorization and Policy Override Center, prescribers may call 800-947-9627.

2) For requests submitted on the ForwardHealth Portal, prescribers can access *www.forwardhealth.wi.gov/.*

3) For PA requests submitted by fax, prescribers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment to ForwardHealth at 608-221-8616.

4) For PA requests submitted by mail, prescribers 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

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 AND PROVIDER 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.

Element 4 — Name — Prescriber
Enter the name of the prescribing provider.

Element 5 — National Provider Identifier (NPI) — Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier (NPI).

Element 6 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 8 — Name — Billing Provider
Enter the name of the billing provider. Prescribers should indicate their name and NPI as the billing provider on the PA request.

Element 9 — NPI — Billing Provider
Enter the 10-digit NPI of the billing provider.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name
Enter the drug name.

Element 11 — Drug Strength
Enter the strength of the drug listed in Element 10.

Element 12 — Date Prescription Written
Enter the date the prescription was written.

Element 13 — Directions for Use
Enter the directions for use of the drug.

Element 14 — Refills
Enter the number of refills.

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form.

Element 15 — 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 16
Check the appropriate box to indicate whether or not the member has an allergy or sensitivity to fish.

Element 17
Check the appropriate box to indicate whether or not the member's triglyceride level has been 500 mg/dL or greater in the past five years. If yes is checked, list the triglyceride level and test date in the space provided.

Element 18
Enter the member's most recent lipid panel, including the date the panel was taken, total cholesterol, high-density lipoprotein (HDL) cholesterol, low-density lipoprotein (LDL) cholesterol, and triglyceride levels in the space provided.

Element 19
Enter the member's current lipid- and triglyceride-lowering therapy, including all drug names, daily doses, and start dates in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR MEMBERS CURRENTLY TAKING AN OMEGA-3 ACID

Element 20
Check the appropriate box to indicate whether or not the member's triglyceride level decreased by 20 percent or more from the baseline. If yes is checked, list test date and triglyceride level in the space provided.

SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED OMEGA-3 ACID REQUESTS ONLY

Element 21
Check the appropriate box to indicate whether or not, in the last year, the member has taken the maximum dose of Lovaza® for at least **four** consecutive months and failed to achieve at least a 30 percent decrease in triglyceride level from baseline. If yes is checked, list the date Lovaza® was taken and the daily dose, the member's baseline triglyceride level prior to starting Lovaza® and the date the test was taken, and the member's triglyceride levels during treatment with Lovaza® and the test dates in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 22 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 23 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 24
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.