FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members 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 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 on the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting a PA for certain drugs. 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, sign, and date the Prior Authorization Drug Attachment for Anti-Obesity Drugs form, F-00163, to request PA for anti-obesity drugs. Prescribers are required to retain a completed copy of the form.

Prescribers may submit PA requests on a Prior Authorization Drug Attachment for Anti-Obesity Drugs form in one of the following ways:

- For PA requests submitted through the Drug Authorization and Policy Override Center, prescribers may call 800-947-9627.
- For PA requests submitted on the ForwardHealth Portal, prescribers may access forwardhealth.wi.gov.
- For PA requests submitted by fax, prescribers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the Prior Authorization Drug Attachment for Anti-Obesity Drugs form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, prescribers should submit a PA/RF and the Prior Authorization Drug Attachment for Anti-Obesity Drugs 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 – PROVIDER INFORMATION

Element 4: Name – Prescriber
Enter the name of the prescriber.

Element 5: Address – Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 6: Phone Number – Prescriber
Enter the phone number, including area code, of the prescriber.

Element 7: National Provider Identifier (NPI) – Prescriber
Enter the 10-digit NPI 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 III – 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: Refills
Enter the number of refills.

Element 14: Directions for Use
Enter the directions for use of the drug.

SECTION IV – CLINICAL INFORMATION
Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Anti-Obesity Drugs 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: Height – Member
Enter the member’s height in inches.

Element 17: Weight – Member
Enter the member’s weight in pounds.

Element 18: Date Member’s Weight Was Measured
Enter the date the member’s weight was measured in mm/dd/ccyy format.

Element 19: Body Mass Index (BMI) – Member
Enter the member's current BMI using the following equation.

$$BMI = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$$

Example: Height = 5'9"
Weight = 230 lbs
Figure out height in inches: 5 x 12 = 60 + 9 = 69

$$BMI = \frac{703 \times 230}{69^2} \qquad BMI = \frac{161690}{4761} \qquad BMI = 33.96$$

Element 20: Goal Weight – Member
Enter the member's goal weight in pounds. This should be a number agreed upon by the prescriber and the member.

SECTION IV A – INITIAL AND RENEWAL COVERAGE REQUIREMENTS
For an initial PA request, the prescriber must complete Sections IV A and IV B. For a renewal PA request, the prescriber must complete Section IV A.

Element 21
Enter the member's age.

Note: Members must be 18 years of age or older for approval of PA requests for anti-obesity drugs, except for Evekeo, orlistat, phentermine/topiramate, Saxenda, Wegovy, and Xenical. Members must be 12 years of age or older to take Evekeo, orlistat, phentermine/topiramate, Saxenda, Wegovy, and Xenical.

Element 22
Check the appropriate box to indicate whether or not the member is pregnant or nursing.

Element 23
Check the appropriate box to indicate whether or not the member has a history of an eating disorder (for example, anorexia, bulimia, or binge eating disorder).

Element 24
Check the appropriate box to indicate whether or not the prescriber has evaluated and determined that the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.

Element 25
Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse.

SECTION IV B – INITIAL COVERAGE REQUIREMENTS
Complete this section for initial PA requests for anti-obesity drugs.

Element 26: BMI Requirements
Check the appropriate box (A, B, C, or D) to indicate which set of BMI requirements the member meets. If B is checked, two or more of the member's current risk factors must also be checked. If cardiovascular disease is checked, the member's history must be supported by one or more of the following (check all that apply):

- Myocardial infarction (heart attack)
- Coronary revascularization
- Angina pectoris
- Stroke
- Intermittent claudication with an ankle-brachial index of less than or equal to 0.9
- Peripheral arterial revascularization due to atherosclerotic disease
- Amputation due to atherosclerotic disease

Element 27
Check the appropriate box to indicate whether or not the member has participated in a weight loss treatment plan (for example, nutritional counseling, an exercise regimen, or a calorie-restricted diet) in the past six months and whether or not the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan in the space provided.

SECTION V – AUTHORIZED SIGNATURE

Element 28: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 29: Date Signed – Prescriber
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION VI – ADDITIONAL INFORMATION

Element 30
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the requested drug may be included.