

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR ANTIEMETICS, CANNABINOIDS 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 applies to Medicaid and SeniorCare.

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 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 items. 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 Antiemetics, Cannabinoids, F-00194. Pharmacy providers are required to use the PA/PDL for Antiemetics, Cannabinoids 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.

Pharmacy providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For requests submitted on the ForwardHealth Portal, prescribers can 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/PDL 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/PDL 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 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

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 – Drug Name

Enter the drug name.

Element 5 – Drug Strength

Enter the strength of the drug listed in Element 4.

Element 6 – Date Prescription Written

Enter the date the prescription was written.

Element 7 – Directions for Use

Enter the directions for use of the drug.

Element 8 – Name – Prescriber

Enter the name of the prescriber.

Element 9 – National Provider Identifier (NPI) – Prescriber

Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 – Address – Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 – Telephone Number – Prescriber

Enter the telephone number, including area code, of the prescriber.

SECTION III – CLINICAL INFORMATION

For PA requests for dronabinol, providers are required to complete Section III and either Section III A or Sections III B and III C of the PA/PDL for Antiemetics, Cannabinoids form.

Element 12 – 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.

SECTION III A – CLINICAL INFORMATION FOR DRONABINOL® FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA

Element 13

Check the appropriate box to indicate whether or not the member is experiencing weight loss or cachexia caused by HIV or AIDS.

Element 14 – Current Height – Member

Enter the member's current height in inches.

Element 15 – Current Weight – Member

Enter the member's current weight in pounds and the month, day, and year the member's weight was taken in the space provided.

Element 16 – Body Mass Index (BMI) – Member

Enter the member's body mass index (BMI). The calculation for BMI is indicated.

Element 17

List the details about the actions used to increase the member's dietary intake.

Element 18

List the details about the member's current dietary plan, including daily caloric intake.

Element 19

Indicate the member's normal baseline weight in pounds.

Element 20

Check the appropriate box to indicate whether or not the member is currently taking dronabinol[®]. If yes is checked, list the date dronabinol[®] was started, the daily dose, and the member's weight prior to starting dronabinol[®] treatment.

SECTION III B – CLINICAL INFORMATION FOR DRONABINOL[®] AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA AND VOMITING

Element 21

Check the appropriate box to indicate whether or not the member is experiencing chemotherapy-related nausea and vomiting.

Element 22

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with ondansetron. If yes is checked, list the date(s) ondansetron was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 23

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

Element 24

Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of ondansetron. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using ondansetron in the space provided.

Element 25

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with granisetron. If yes is checked, list the dates granisetron was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 26

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug(s) the member is taking and granisetron. If yes is checked, list the drug(s) and interaction(s) 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 granisetron. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using granisetron in the space provided.

Element 28

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant drug reaction with Emend[®]. If yes is checked, list the dates Emend[®] was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 29

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug(s) the member is taking and Emend[®]. If yes is checked, list the drug(s) and interaction(s) in the space provided.

Element 30

Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents the use of Emend[®]. If yes is checked, list the medical condition(s) and describe how the condition(s) prevents the member from using Emend[®] in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

Element 31 – Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 32 – Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V – ADDITIONAL INFORMATION

Element 33

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