FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTIEMETICS, CANNABINOIDS 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.

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, 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 Drug Attachment for Antiemetics, Cannabinoids, F-00194. Pharmacy providers are required to use the Prior Authorization Drug Attachment 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 drug attachment form in one of the following ways:

- For requests submitted on the ForwardHealth Portal, prescribers can access www.forwardhealth.wi.gov/.
- For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate drug attachment form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate drug attachment 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 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 Enrollment Verification System do not match, use the spelling from the Enrollment Verification System.

Element 2: Member ID Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the Enrollment Verification System 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 – Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

Element 10: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescriber.

Element 11: Phone Number – Prescriber
Enter the phone 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 Prior Authorization Drug Attachment for Antiemetics, Cannabinoids form.

Element 12: Diagnosis Code and Description
Enter the appropriate and most specific International Classification of Diseases diagnosis code and description most relevant to the drug requested. The International Classification of Diseases diagnosis code must correspond with the International Classification of Diseases description.

SECTION III A – CLINICAL INFORMATION FOR DRONABINOL FOR ANOREXIA ASSOCIATED WITH WEIGHT LOSS WITH AIDS

Note: A copy of the member's medical records must be submitted with the PA request.

Element 13
Check the appropriate box to indicate whether or not the member has AIDS.

Element 14
Check the appropriate box to indicate whether or not the member is experiencing anorexia associated with weight loss.

Element 15
Enter the member's current height in inches; current weight in pounds; the month, day, and year the member's weight was taken; and the member's current body mass index. The calculation for body mass index is indicated.

Element 16
Enter the member's baseline weight in pounds; the month, day, and year the baseline weight was taken; and the member's baseline body mass index. The calculation for body mass index is indicated.

Element 17
Check the appropriate box to indicate whether or not the member's daily caloric intake has been optimized.

Element 18
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.

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

Note: A copy of the member's medical records must be submitted with the PA request.

Element 19
Check the appropriate box to indicate whether or not the member is currently receiving chemotherapy.

Element 20
Check the appropriate box to indicate whether or not the member is experiencing chemotherapy-related nausea and vomiting.

Element 21
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 22
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 23
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 24
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 date(s) granisetron was taken, and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 25
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 26
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 27
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant drug reaction with at least one of the following chemotherapy-related nausea and vomiting treatments: dexamethasone, haloperidol, lorazepam, metoclopramide, olanzapine, prochlorperazine, or promethazine. If yes is checked, list the drug names(s) and approximate date(s) taken, and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

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

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

SECTION V – ADDITIONAL INFORMATION

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