FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS 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.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the Pharmacy service area of the ForwardHealth Online Handbook 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 Glucagon-Like Peptide (GLP-1) Agents, F-00238, to request PA for GLP-1 agents. Pharmacy providers are required to use the PA/PDL for GLP-1 Agents 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, pharmacy providers may 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 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 Wisconsin's 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 drug.

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 — 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 GLP-1 Agents form.

Element 13 — 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 14
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the member has type 2 diabetes mellitus.

Element 16
Check the appropriate box to indicate whether or not the member currently has or is there a history of pancreatitis.

Element 17
Check the appropriate box to indicate whether or not the member currently has or is there a history of gastroparesis.

Element 18
Indicate the member's most current hemoglobin (HbA1c).

Element 19
Indicate the date the member's most current HbA1c was measured in MM/DD/CCYY format. The member's most current HbA1c measurement must be within the past six months.

Element 20
Indicate the drug name, daily dose, and start date of the member's current GLP-1 therapy. Check "none" if appropriate.

Element 21
Indicate the drug name, daily dose, dates taken, and the reason(s) for discontinuation for the member's previous GLP-1 therapy in the spaces provided. Check "none" if appropriate.

Element 22

Enter detailed documentation in the spaces provided regarding why the member is unable to take or has previously discontinued **at least two** of the following GLP-1 treatments: Bydureon, Byetta, and Tanzeum. The following will **not** be considered as criteria to support the need for a non-preferred GLP-1 agent:

- Non-adherence to previous GLP-1 treatment.
- Member or prescriber preference for the use of a non-preferred GLP-1 agent.
- Member or prescriber preference for a less frequent dosing schedule.

SECTION V — AUTHORIZED SIGNATURE

Element 23 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 24 — Date Signed

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

SECTION VI — ADDITIONAL INFORMATION

Element 25

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