FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS 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, 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 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 Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents, F-00238, to request PA for GLP-1 agents. Pharmacy providers are required to use the Prior Authorization Drug Attachment 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 in one of the following ways:

- For requests submitted on the ForwardHealth Portal, pharmacy providers may 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 attachment to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate attachment 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 Wisconsin's 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

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 – Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

Element 11: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescriber.

Element 12: Phone Number – Prescriber
Enter the phone number, including area code, of the prescriber.

SECTION III – CLINICAL INFORMATION
Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for GLP-1 Agents form.

Element 13: 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.

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 pancreatitis or has a history of pancreatitis.

Element 17
Indicate the member’s most current hemoglobin A1c.

Element 18
Indicate the date the member’s most current hemoglobin A1c was measured in mm/dd/ccyy format. The member’s most current hemoglobin A1c measurement must be within the past six months.

Element 19
Indicate the drug name, dose, and start date of the member's current GLP-1 therapy. Check "None" if appropriate.

Element 20
Indicate the drug name, dose, date(s) taken, and the reason(s) for discontinuation for the member's previous GLP-1 therapy in the spaces provided. Check "None" if appropriate.

Element 21
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: exenatide (Bydureon Pen/Byetta), Trulicity, and Victoza. The following will **not** be considered as criteria to support the need for a non-preferred GLP-1 agent:

- Nonadherence to previous GLP-1 treatment
- Member fear of needles
- Member or prescriber preference for the use of an oral agent
- Member or prescriber preference for the use of a non-preferred GLP-1 agent
- Member or prescriber preference for a less frequent dosing schedule

Note: ForwardHealth will only consider use of exenatide (Bydureon Pen/Byetta) as one of the preferred GLP-1 agent treatments.

SECTION V – 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 VI – ADDITIONAL INFORMATION

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