FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) ORALLY DISINTEGRATING TABLETS 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 services.

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 medical consultants to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete, sign, and date the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets form, F-00433. Pharmacy providers are required to use the PA/PDL for PPI Orally Disintegrating Tablets form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or 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 PA form.

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

- For STAT-PA requests, pharmacy providers should call 800-947-1197.
- For PA requests submitted on the 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 PA/PDL form to ForwardHealth at 608-221-8616.
- 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

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: 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.

Element 12: National Provider Identifier (NPI) – Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

SECTION III – CLINICAL INFORMATION (Required for All Requests)
Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for PPI Orally Disintegrating Tablets 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 box to indicate whether or not the member is 5 years of age or older.

Element 15
Check the box to indicate whether or not the member has a medical condition(s) that prevents the member from using PPI capsules and non-orally disintegrating tablets. If yes, list the medical condition(s) and describe how it prevents the member from using PPI capsules and non-orally disintegrating tablets.

Element 16
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Nexium DR packet. If yes, list the dates Nexium DR packet was taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Element 17
Check the box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Nexium DR packet. If yes, list the drug(s) and interaction(s) in the space provided.

Element 18
Check the box to indicate whether or not the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Protonix suspension. If yes, list the approximate dates Protonix was taken and details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction in the space provided.

Element 19
Check the box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and Protonix suspension. If yes, list the drug(s) and interaction(s) in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

Element 20: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 21: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

Element 22: National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 23: Days' Supply Requested
Enter the requested days' supply.

Element 24: NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 25: Date of Service
Enter the requested first date of service (DOS) for the drug in mm/dd/ccyy format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 26: Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Code	Description
01	Pharmacy
13	Assisted living facility
14	Group home
32	Nursing facility
34	Hospice
50	Federally qualified health center
65	End-stage renal disease treatment facility
72	Rural health clinic

Element 27: Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 28: Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 29: Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 30: Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VI – ADDITIONAL INFORMATION

Element 31
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.