FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTIPSYCHOTIC DRUGS FOR CHILDREN 8 YEARS OF AGE AND YOUNGER 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 also applies to Medicaid.

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 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 Antipsychotic Drugs for Children 8 Years of Age and Younger, F-00556. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger 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 form.

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

1) For STAT-PA requests, pharmacy providers should call 800-947-1197.

2) For requests submitted on the ForwardHealth Portal, pharmacy providers may access www.forwardhealth.wi.gov/.

3) For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA attachment to ForwardHealth at 608-221-8616.

4) For PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA 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 (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 drug name.

Element 5 – Drug Strength
Enter the strength of the drug listed in Element 4.

Element 6 – National Drug Code (NDC)
Enter the NDC of the drug prescribed.

Element 7 – Date Prescription Written
Enter the date the prescription was written.

Element 8 – Directions for Use
Enter the directions for use of the drug.

Element 9 – Start Date Requested
Enter the requested start date.

Element 10 – Name – Prescriber
Enter the name of the prescribing provider.

Element 11 – National Provider Identifier (NPI) – Prescriber
Enter the prescribing provider's 10-digit NPI.

Element 12 – Address – Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 13a – Telephone Number – Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 13b
In case the PA consultant needs additional information about the child, provide a contact person's name and telephone number at the clinic where the child was seen who can be contacted to discuss the child's clinical information.

SECTION III – DIAGNOSIS INFORMATION

Element 14 – 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 15
Check the appropriate box to indicate whether or not the child has one of the conditions listed.

Prescriber Responsibilities
If the response to either condition listed is yes, no additional clinical information is required on the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form; the prescriber should skip to Section XI (Authorized Signature) and sign and date this form.

If the response to both conditions in Element 15 is no, the prescriber is required to complete the entire form.

Prescribers should submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Pharmacy Responsibilities
If the response to either condition listed is yes, pharmacy providers are encouraged to submit the completed Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form to ForwardHealth using the STAT-PA system.

If the response to both conditions listed is no, pharmacy providers should complete a PA/RF and submit it with a completed Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger to ForwardHealth on the Portal, by fax, or by mail.

SECTION III A – ADDITIONAL DIAGNOSIS INFORMATION

Element 16 – Additional Diagnosis Codes and Descriptions Related to Behavioral Health Conditions
Enter the appropriate and most-specific secondary ICD diagnosis codes and descriptions most relevant to the drug requested. The ICD diagnosis codes must correspond with their respective ICD descriptions.

SECTION IV – BODY MASS INDEX (BMI) INFORMATION

Element 17 – Height – Child
Enter the child's height in inches.

Element 18 – Weight – Child
Enter the child's weight in pounds.

Element 19 – Date of Child's Weight Measurement
Enter the date the child's weight was measured in MM/CCYY format.

Element 20 – BMI – Child
Enter the child's most current BMI using the following equation. Indicate the child's most current BMI as a three-digit number (e.g., if the child's BMI is 33, enter 33.0).

Refer to the formula below or to the BMI calculator on the Centers for Disease Control and Prevention website at nccd.cdc.gov/dnpabmi/Calculator.aspx.

$$BMI = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$$

Example: Height = 3'4"
Weight = 80 lbs
Figure out height in inches: 3x12 = 36 + 4 = 40

$$BMI = \frac{703 \times 80}{40^2} \qquad BMI = \frac{56240}{1600} \qquad BMI = 35.15$$

Element 21 – BMI Percentile
Enter the child's current BMI percentile.

SECTION V – CLINICAL INFORMATION FOR CHILDREN WITH A BMI PERCENTILE ≥ 85

Element 22
Indicate in the spaces provided the child's most recent triglyceride level, fasting glucose **or** hemoglobin A1c (HBA1c), and the date(s) taken. The date(s) listed must be within the past **six** months.

SECTION VI – MEDICATION USE

Element 23
Check the appropriate box to indicate whether or not the child is currently taking the antipsychotic drug being requested.

Element 24
Check the appropriate boxes to indicate whether or not the child is currently taking a selective serotonin reuptake inhibitor (SSRI) and whether or not the child has taken an SSRI in the past.

Element 25
Indicate in the space provided the child's experience with psychoactive medication(s) other than the drug being requested. List the drugs and the highest daily doses achieved that the child is currently taking and has taken in the past in the spaces provided.

SECTION VII – ADDITIONAL CLINICAL INFORMATION

Element 26
Check the appropriate box(es) to indicate which of the diagnoses or symptoms (i.e., symptom[s] of persistent irritability/anger [daily or nearly daily], symptom[s] of temper outbursts [three or more per week], or symptom[s] of anxiety) apply to the child. If yes to symptoms of anxiety, describe.

SECTION VIII – PRESCRIBER SPECIALITY INFORMATION

Element 27
Check the appropriate box to indicate the specialty (i.e., Child Psychiatrist Board Certified, Child Psychiatrist Board Eligible, Developmental-Behavioral Pediatrician Board Certified, or other specialty) of the prescribing provider. If other, enter the specific specialty in the space provided.

SECTION IX — DOCUMENTATION FOR A NON-PREFERRED ANTIPSYCHOTIC DRUG
This section does not need to be completed if the drug being requested is a preferred antipsychotic drug on the ForwardHealth Preferred Drug List (PDL).

Element 28
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the preferred drugs from the same PDL drug class as the drug being requested. If the child has taken a preferred drug(s), list the preferred drug(s) used, the dates the preferred drug(s) was taken, and describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) in the space provided.

SECTION X – FOR PHARMACY PROVIDERS USING STAT-PA

Element 29 – NDC
Enter the appropriate 11-digit NDC for each drug.

Element 30 – Days' Supply Requested
Enter the requested days' supply.

Element 31 – NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider taxonomy code is not 333600000X.

Element 32 – 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 33 – 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 34 – Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 35 – Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 36 – Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

SECTION XI – AUTHORIZED SIGNATURE

Element 37 – Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 38 – Date Signed
Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION XII – ADDITIONAL INFORMATION

Element 39
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.