FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MULTIPLE SCLEROSIS (MS) 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 services.

The use of this form is mandatory when requesting a PA for certain drugs. Attach additional pages if more space is needed. 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 Multiple Sclerosis (MS) Agents form, F-00805. Pharmacy providers are required to use the Prior Authorization Drug Attachment for MS Agents form to request PA for non-preferred MS agents 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.

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

- For PA requests submitted on the Portal, pharmacy providers may access www.forwardhealth.wi.gov.
- For PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment form to ForwardHealth at 608-221-8616.
- 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 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

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

SECTION III – CLINICAL INFORMATION (Required for All PA Requests)
Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for MS 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
Indicate the drug name, daily dose, and start date of the member's current MS agents therapy. Check "None" if appropriate.

Element 15
Indicate the drug name, daily dose, dates taken, and the reason(s) for discontinuation for the member's previous MS agents therapy. Check "None" if appropriate.

SECTION IV – CLINICAL INFORMATION FOR NON-PREFERRED ORAL MS AGENTS (ORAL AGENTS)

Element 16
Provide detailed documentation in the spaces provided regarding why the member is unable to take or has previously discontinued Aubagio treatment, Gilenya treatment, and Tecfidera treatment. **Medical records must be provided** to support the need for the non-preferred oral agent. The following will **not** be considered as criteria to support the need for a non-preferred oral agent:

- Nonadherence to previous MS treatment
- Member or prescriber preference for the use of a non-preferred oral agent

SECTION V – CLINICAL INFORMATION FOR KESIMPTA

Element 17
Provide detailed documentation in the spaces provided regarding why the member is unable to take or has previously discontinued Gilenya treatment and Tecfidera treatment. **Medical records must be provided** to support the need for Kesimpta. The following will **not** be considered as criteria to support the need for Kesimpta:

- Nonadherence to previous MS treatment
- Member or prescriber preference for the use of Kesimpta

SECTION VI – CLINICAL INFORMATION FOR NON-PREFERRED INTERFERONS, MS AGENTS (INTERFERONS)

Element 18
Provide detailed documentation in the spaces provided regarding why the member is unable to take or has previously discontinued **at least two** preferred interferons. **Medical records must be provided** to support the need for a non-preferred interferon. The following will **not** be considered as criteria to support the need for a non-preferred interferon:

- Nonadherence to previous MS treatment
- Member or prescriber preference for the use of a non-preferred interferon
- Member or prescriber preference for a less frequent dosing schedule

SECTION VII – CLINICAL INFORMATION FOR GLATOPA

Element 19
Provide detailed clinical justification in the space provided for prescribing Glatopa instead of the preferred MS agents Copaxone 20 mg and Copaxone 40 mg. This clinical information must document why the member cannot use Copaxone 20 mg and Copaxone 40 mg, including why it is medically necessary that the member receive Glatopa instead of Copaxone 20 mg and Copaxone 40 mg.

SECTION VIII – 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 IX – ADDITIONAL INFORMATION

Element 22
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included.