

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS 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 only 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 Hepatitis C Agents form, F-01247. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Hepatitis C 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.

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

- For requests submitted on the ForwardHealth Portal, pharmacy providers can 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 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 (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: Date Prescription Written

Enter the date the prescription was written.

Element 5: Name – Prescriber

Enter the name of the prescribing provider.

Element 6: National Provider Identifier – Prescriber

Enter the prescribing provider's 10-digit National Provider Identifier.

Element 7: Address – Prescriber

Enter the address (street, city, state, and zip+4 code) of the prescriber.

Element 8: Phone Number – Prescriber

Enter the phone number, including area code, of the prescriber.

Element 9

Indicate the drug name, daily dose, and expected duration for the proposed hepatitis C drug treatment regimen. Indicate whether or not the member is currently taking the drug. If the member is currently taking this drug, enter the date started.

SECTION III – CLINICAL INFORMATION

Element 10: 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.

Note: A copy of the member's medical records that document the following must be submitted with the PA request:

- Hepatitis C virus (HCV) assessment and treatment plan
- Current history and physical, including complete problem and medication list
- Lab tests performed (within the last **six months**): albumin, complete blood count (CBC), international normalized ratio (INR), liver function panel, serum creatinine, and HCV-ribonucleic acid (HCV-RNA) level

Element 11

Provide the date (in mm/dd/ccyy format) that the member was diagnosed with HCV, and indicate the likely source of the HCV Infection.

Element 12

Indicate the member's HCV genotype and subtype and the HCV-RNA level and the date(s) performed.

Note: A copy of the lab results **must** be submitted with the PA request.

Element 13

Indicate the member's previous HCV treatment. Check the appropriate box to indicate whether or not the member is HCV treatment naïve. Check the appropriate box to indicate whether or not the member has had previous pegylated interferon/ribavirin treatment or direct-acting antiviral (DAA) HCV treatment. If the member has received previous HCV treatment, provide the drug name, dates taken, and treatment results.

Element 14

Check the appropriate box to indicate whether or not the member has had a liver biopsy, imaging studies, or blood assay tests to determine hepatic fibrosis. If yes, list the test performed, fibrosis stage (F), and date the test was performed in the spaces provided.

Note: A copy of the results **must** be submitted with the PA request.

Element 15

Check the appropriate box to indicate whether or not the member has cirrhosis. If yes, complete Section III A of the form.

SECTION III A – CLINICAL INFORMATION REQUIRED FOR MEMBERS WITH CIRRHOSIS ONLY

Element 16

If the member has cirrhosis, indicate the member's current Child-Turcotte-Pugh (CTP) class, score, and the date calculated.

Element 17

Check the appropriate box to indicate whether or not the member has or is being treated for ascites, hepatic encephalopathy, portal hypertension, and hepatocellular cancer.

Element 18

Check the appropriate box to indicate whether or not the member has had medical imaging to screen for hepatocellular carcinoma within the last six months.

Note: A copy of the medical imaging results **must** be submitted with the PA request.

SECTION IV – AUTHORIZED SIGNATURE

Element 19: Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 20: Date Signed

Enter the date the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 21

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