FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE AND ULCERATIVE COLITIS 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 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. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form, F-01950. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis 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 on a 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

Providers and prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation. 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
If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4: Drug Name
Enter the drug name.

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: Directions for Use
Enter the directions for use of the drug.

Element 8: Name – Prescriber
Enter the name of the prescriber.

Element 9: National Provider Identifier – Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

Element 10: Address – Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip+4 code.

Element 11: Phone Number – Prescriber
Enter the phone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III A – CLINICAL INFORMATION FOR CROHN'S DISEASE AND ULCERATIVE COLITIS
Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III A for all PA requests. In addition, complete Section III B for PA requests for Xeljanz XR. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12: 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.

Note: A copy of the member's medical records must be submitted with the PA request to support the condition being treated, details regarding previous medication use, and outline the member's current treatment plan.

Element 13
Check the appropriate box to indicate whether or not the member has Crohn's disease.

Element 14
Check the appropriate box to indicate whether or not the member has ulcerative colitis.

Element 15
Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

Element 16
Check the appropriate box to indicate whether or not the member is currently using the requested cytokine and CAM antagonist drug. If yes, indicate in the space provided the approximate date that therapy was started.

Element 17
Check the appropriate box to indicate whether or not the member has attempted any of the following drugs for Crohn's disease or ulcerative colitis: 6 mercaptopurine (6MP), azathioprine, oral aminosalicylates (balsalazide, mesalamine, olsalazine, sulfasalazine), or methotrexate.

If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section V of the form.

Element 18
Check the appropriate box to indicate whether or not the member has attempted other drugs for Crohn's disease or ulcerative colitis (for example, antibiotics, glucocorticoids, or IV immunomodulators such as infliximab). If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section V of the form.

Element 19
Indicate the cytokine and CAM antagonist drugs the member has taken, dose, dates taken, and specific details regarding the treatment response. If additional space is needed, continue documentation in Section V of the form.

Element 20
Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ XR REQUESTS

Element 21
PA requests for Xeljanz XR must include detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. This clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

SECTION IV – 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 V – ADDITIONAL INFORMATION

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