FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR UVEITIS, GIANT CELL ARTERITIS, AND NEONATAL ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID) 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/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis, Giant Cell Arteritis, and Neonatal Onset Multisystem Inflammatory Disease (NOMID) form, F-01952. Prescribers and pharmacy providers are required to retain a completed copy of the form.

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

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

2) For paper PA requests 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.

3) For paper PA requests 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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. 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
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 (NPI) – Prescriber
Enter the 10-digit NPI 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 – Telephone Number – Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III – CLINICAL INFORMATION
Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. 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* (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

SECTION III A – CLINICAL INFORMATION FOR HUMIRA® FOR UVEITIS ONLY

Element 13
Check the appropriate box to indicate whether or not the member has noninfectious uveitis.

Element 14
Check the appropriate box to indicate whether or not the prescription was written by an ophthalmologist or rheumatologist or through an ophthalmology rheumatology consultation.

Element 15
Check the appropriate box to indicate whether or not the member is currently using the requested cytokine and CAM antagonist drug. If yes, indicate the approximate date therapy was started.

Element 16
Check the appropriate box next to the drugs listed that the member has taken for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Indicate the drug name, dose, dates taken, and reason for discontinuation.

Check "none" if appropriate, and indicate the reason the member is unable to use the drugs listed.

Note: **If none, 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.**

SECTION III B – CLINICAL INFORMATION FOR ACTEMRA® FOR GIANT CELL ARTERITIS ONLY

Element 17
Check the appropriate box to indicate whether or not the member has giant cell arteritis.

Element 18
Check the appropriate box to indicate whether or not the prescription was written by a rheumatologist or through a rheumatology consultation.

Element 19
Indicate whether or not the member is currently using Actemra®. If yes, indicate the approximate date therapy was started.

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.**

SECTION III C – CLINICAL INFORMATION FOR KINERET® FOR NOMID ONLY

Element 20
Check the appropriate box to indicate whether or not the member has NOMID.

Element 21
Check the appropriate box to indicate whether or not the prescription was written by a rheumatologist or through a rheumatology consultation.

Element 22
Check the appropriate box to indicate whether or not the member is currently using Kineret®. If yes, indicate the approximate date therapy was started.

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.**

SECTION IV – AUTHORIZED SIGNATURE

Element 23 – Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 24 – Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V – ADDITIONAL INFORMATION

Element 25
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.