

FORWARDHEALTH
**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MIGRAINE AGENTS,
CALCITONIN GENE-RELATED PEPTIDE (CGRP) ANTAGONISTS 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 PA for certain drugs. If necessary, 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 Migraine Agents, Calcitonin Gene-Related Peptide (CGRP) Antagonists, F-02371. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Migraine Agents, CGRP Antagonists 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 PA drug attachment form in one of the following ways:

- For requests submitted on the ForwardHealth Portal, pharmacy providers may 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 submitted 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 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: National Provider Identifier – Prescriber

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

Element 11: Address – Prescriber

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

Element 12: Phone Number – Prescriber

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

SECTION III – CLINICAL INFORMATION – ALL REQUESTS

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Migraine Agents, CGRP Antagonists form.

Element 13: 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 must be submitted with all PA requests for migraine agents, CGRP antagonist drugs. Medical records must document the member's medical work-up for migraines, including complete problem and medication lists.

SECTION IV – CLINICAL INFORMATION – INITIAL REQUESTS ONLY

Element 14

Check the box to indicate whether or not the drug requested is a preferred migraine agent, CGRP antagonist. If the drug is a non-preferred migraine agent, CGRP antagonist, describe the reason for the request in the space provided.

Element 15

Check the box to indicate whether or not the member is 18 years of age or older.

Element 16

Check the box to indicate whether or not the prescriber has evaluated and diagnosed the member as having a history of migraine, with or without aura, according to the International Classification of Headache Disorders, 3rd edition (ICHD-3) diagnosis criteria.

Element 17

Check the box to indicate whether or not the prescriber has confirmed the member's headaches are not due to medication overuse.

Element 18

In the spaces provided, document the member's current headache frequency (headache days per month, migraine days per month, and average migraine duration in hours) and prescribed medication treatment regimen. List current prescribed headache prophylaxis medications (drug name[s], **including Botox [if applicable]**; dose; and dosing frequency). List current prescribed headache rescue medications (drug name[s], dose, and dosing frequency). Check the box to indicate whether or not the member has been compliant with the current prescribed headache medication treatment regimen.

Element 19

Check the boxes next to the drug categories (angiotensin-converting enzyme [ACE] inhibitors/angiotensin receptor blockers [ARBs], anticonvulsants, antidepressants, beta blockers, calcium channel blockers) from which the member has tried migraine prophylaxis medications. In the space provided, document the following:

- The names of the medications tried
- The approximate dates the medications were received
- Specific details about the treatment results, including if the medications resulted in an unsatisfactory therapeutic response(s) or a clinically significant adverse drug reaction(s)

Check the box to indicate whether or not the member has tried migraine prophylaxis medications from **at least two** of the drug categories listed on the form.

If no, check the box to indicate whether or not the member has a medical condition(s) **or** there is a clinically significant drug interaction(s) with a medication the member is taking that prevents them from taking a drug in each of the drug categories listed. If yes, document the drug category and medical condition(s) or clinically significant drug interaction(s) that prevent the member from taking a drug in any of the drug categories the member has not attempted.

Element 20

Document the member's proposed headache medication treatment regimen. List the proposed headache prophylaxis medications (drug name[s], **including Botox [if applicable] and the requested CGRP antagonist**; dose; and dosing frequency). Also list the proposed headache rescue medications (drug name[s], dose, and dosing frequency).

Element 21

Check the box to indicate whether or not the member has taken a preferred migraine agent, CGRP antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes, indicate the preferred migraine agent, CGRP antagonist drug name, the dose, the approximate dates taken, and specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY

Element 22

Check the box to indicate whether or not the member has experienced/sustained a clinically significant decrease in the number of migraine days per month compared to their baseline prior to initiation of treatment with a migraine agent, CGRP antagonist drug. If yes, indicate the current number of headache days per month, the number of migraine days per month, and the average migraine duration (in hours).

Element 23

List the current prescribed headache prophylaxis medications (drug name[s], **including Botox [if applicable] and the requested CGRP antagonist**; dose; and dosing frequency). Also list the current prescribed headache rescue medications (drug name[s], dose, and dosing frequency). Check the box to indicate whether or not the member has been compliant with the current prescribed headache medication treatment regimen.

SECTION VI – AUTHORIZED SIGNATURE

Element 24: Signature – Prescriber

The prescriber is required to sign and date this form.

Element 25: Date Signed

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

SECTION VII – ADDITIONAL INFORMATION

Element 26

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