FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) 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/Preferred Drug List (PA/PDL) for Migraine Agents, Calcitonin Gene-Related Peptide (CGRP) Antagonists, F-02371. Pharmacy providers are required to use the PA/PDL for Migraine Agents, CGRP Antagonists form to request PA by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Pharmacy providers may submit PA requests on a PA/PDL 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/PDL form to ForwardHealth at 608-221-8616.
- For PA requests submitted 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

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 PA/PDL 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 the PA request, including the following:
- The member's medical work-up for migraines, including complete problem and medication list
- Details regarding previous medication use
- The member's current migraine treatment plan
- The average number of headache days and migraine days the member has per month

SECTION IV – CLINICAL INFORMATION – INITIAL REQUESTS ONLY

Element 14
Check the box to indicate whether or not the member is 18 years of age or older.

Element 15
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 16
Check the box to indicate whether or not the member has experienced episodic migraines (less than 15 headache days per month with four to 14 migraine days per month) for three or more months. If yes, indicate the number of headache days and migraine days per month.

Element 17
Check the box to indicate whether or not the member has experienced chronic migraines (15 or more headache days per month with eight or more migraine days per month) for three or more months. If yes, indicate the number of headache days and migraine days per month.

Element 18
Check the box to indicate whether or not the prescriber has confirmed the member's headaches are not due to medication overuse or attributed to another causative disorder.

Element 19
Check the box to indicate whether or not the prescriber has discussed alternative non-pharmacological treatment options with the member, such as behavioral therapies, physical therapies, and lifestyle modifications.

Element 20
Check the boxes next to the drug categories (antidepressants, anticonvulsants, 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 a medical condition(s) **or** there is a clinically significant drug interaction(s) with a medication the member is currently taking that prevents them from taking **two or more** of the drug categories listed. If yes, document the drug name(s), approximate date(s) taken, and the reason for discontinuation or a medical condition(s) and/or drug interaction(s) that prevents the member from taking a drug from **two or more** of the drug categories listed.

SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY

Element 21
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 migraine days per month.

Element 22
Check the box to indicate whether or not the prescriber has confirmed the member's headaches are not due to medication overuse or attributed to another causative disorder.

Element 23
Document the member's current migraine treatment plan, including medications and non-pharmacologic treatments (that is, behavioral therapies, physical therapies, lifestyle modifications).

Element 24
Check the box to indicate whether or not the member has been compliant with the documented migraine treatment plan, including medication adherence and non-pharmacologic treatments (that is, behavioral therapies, physical therapies, lifestyle modifications).

SECTION VI – AUTHORIZED SIGNATURE

Element 25: Signature – Prescriber
The prescriber is required to sign and date this form.

Element 26: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION VII – ADDITIONAL INFORMATION

Element 27
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.