FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR NON-PREFERRED STIMULANTS, RELATED AGENTS - WAKE PROMOTING 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 a PA for certain drugs. 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 Non-Preferred Stimulants, Related Agents - Wake Promoting form, F-02537. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting 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 in one of the following ways:

- For requests submitted on the 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

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
Providers should enter only the name and strength of the drug for which PA is being requested.

Element 4: Drug Name
Enter the name of the drug.

Element 5: Drug Strength
Enter the strength of the drug in milligrams.

Element 6: Date Prescription Written
Enter the date that the prescription was written.

Element 7: Directions for Use
Enter the directions for use of the drug.

Element 8: Refills
Enter the number of refills.

Element 9: Name – Prescriber
Enter the name of the prescriber.

Element 10: National Provider Identifier – Prescriber
Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

Element 11: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescribing provider.

Element 12: Phone Number – Prescriber
Enter the phone number, including area code, of the prescribing provider.

SECTION III – CLINICAL INFORMATION
Required for all requests. Prescribers are required to complete Section III for all PA requests and either Section III A or III B before signing and dating the Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting form.

Element 13: Diagnosis Code and Description
Enter the appropriate and most specific International Classification of Diseases (ICD) diagnosis code and description relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

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

Element 15
Check the appropriate box to indicate whether or not the member is taking any drugs in the stimulants, related agents - wake promoting class. If yes, list the drug name(s) and dosage.

Element 16
Check the appropriate box to indicate whether or not the member has tried armodafinil and either experienced an unsatisfactory therapeutic response after the medication was titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction. If yes, list the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates armodafinil was taken.

Element 17
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of armodafinil. If yes, list the medical condition(s) that prevents the use of armodafinil.

Element 18
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and armodafinil. If yes, list the medication(s) and interaction(s).

Element 19
Check the appropriate box to indicate whether or not the member has tried modafinil and either experienced an unsatisfactory therapeutic response after the medication was titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction. If yes, list the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates modafinil was taken.

Element 20
Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of modafinil. If yes, list the medical condition(s) that prevents the use of modafinil.

Element 21
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and modafinil. If yes, list the medication(s) and interaction(s).

SECTION III A – CLINICAL INFORMATION FOR NARCOLEPSY ONLY
Prescribers are required to complete Section III for all PA requests and either Section III A or III B before signing and dating the Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting form. Complete Section III A if the request is for a member with narcolepsy.

Element 22
Check the appropriate box to indicate whether or not the member has excessive daytime sleepiness associated with narcolepsy.

Element 23
Check the appropriate box to indicate whether or not the member has had an overnight polysomnogram (PSG) sleep study followed by a multiple sleep latency test (MSLT) that confirms the member has narcolepsy. If yes, respond to the following questions on the form regarding PSG and MSLT sleep studies.

PSG
A. Was the member's total sleep time less than 360 minutes?
B. Did the member experience significant sleep interruptions (for example, respiratory events or periodic leg movements)?
C. Did the provider interpretation indicate that the member had an adequate night's sleep?

MSLT
D. Was the MSLT conducted the morning after the overnight PSG?
E. Was the average sleep latency for all naps greater than eight minutes?
F. Indicate the number of sleep onset rapid eye movement periods (SOREMPs) the member achieved during the MSLT (0 = no SOREMPs, 1 = one SOREMP, 2 = two or more SOREMPs).

The provider is required to submit the test results and provider interpretation for the PSG and MSLT, along with medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy.

Element 24
Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

Element 25
Check the appropriate box to indicate whether or not the member is taking central nervous system depressants (for example, anxiolytics, barbiturates, or opioids). If yes, indicate the central nervous system depressants and daily doses in the spaces provided on the form. Indicate whether or not any of the listed central nervous system depressants contribute to the member's daytime sleepiness. If not, indicate how the prescriber evaluated the central nervous system depressants and determined they are not contributing to the member's daytime sleepiness.

SECTION III B – CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA ONLY
Prescribers are required to complete Section III for all PA requests and either Section III A or III B before signing and dating the Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting form. Complete Section III B if the request is for a member with obstructive sleep apnea.

Element 26
Check the appropriate box to indicate whether or not the member is taking any stimulants.

Element 27
Check the appropriate box to indicate whether or not the member has excessive daytime sleepiness associated with obstructive sleep apnea.

Element 28
Check the appropriate box to indicate whether or not the member has had an overnight PSG sleep study with an Apnea-Hypopnea Index greater than or equal to five events per hour. Indicate the date of the PSG and the member's resulting Apnea-Hypopnea Index in the spaces provided on the form.

If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG.

Element 29
Check the appropriate box to indicate whether or not the member is using continuous positive airway pressure (CPAP). If yes, check the appropriate box to indicate whether or not the member will continue to use CPAP in combination with the requested non-preferred stimulants, related agents - wake promoting drug.

SECTION IV – AUTHORIZED SIGNATURE

Element 30: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 31: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 32
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.