FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR EUCRISA 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 only 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. 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 Eucrisa form, F-02572. Pharmacy providers are required to use the PA/PDL for Eucrisa form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or 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/PDL form in one of the following ways:

- For STAT-PA requests, pharmacy providers should call 800-947-1197.
- For requests submitted on the ForwardHealth 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/PDL form to ForwardHealth at 608-221-8616.
- For 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

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 submit a copy of the prescription.

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 prescriber.

SECTION III – CLINICAL INFORMATION

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.

Element 13
Check the appropriate box to indicate whether or not the member has atopic dermatitis.

Element 14
Check the appropriate box to indicate whether or not the member has used a topical steroid for at least two consecutive months and experienced an unsatisfactory therapeutic response. If yes, list name and strength of the topical steroid, specific details about the unsatisfactory therapeutic response, and the approximate dates that the topical steroid was used in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member has used a topical steroid and experienced a clinically significant adverse drug reaction. If yes, list the name and strength of the topical steroid, specific details about the significant adverse drug reaction, and the approximate dates that the topical steroid was used in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member has used Elidel or Protopic for at least two consecutive months and experienced an unsatisfactory therapeutic response. If yes, list the name and strength of the drug used, specific details about the unsatisfactory therapeutic response, and the approximate dates that Elidel or Protopic was used in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has used Elidel or Protopic and experienced a clinically significant adverse drug reaction. If yes, list the name of the drug used, the strength, specific details about the significant adverse drug reaction, and the approximate dates that Elidel or Protopic was used in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

Element 18: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 19: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

Element 20: National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21: Days' Supply Requested
Enter the requested days' supply up to 365 days.

Element 22: National Provider Identifier
Enter the National Provider Identifier. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 23: Date of Service
Enter the requested first date of service for the drug in mm/dd/ccyy format. For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.

Element 24: Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Code	Description
01	Pharmacy
13	Assisted living facility
14	Group home
32	Nursing facility
34	Hospice
50	Federally qualified health center
65	End-stage renal disease treatment facility
72	Rural health clinic

Element 25: Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 26: Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 27: Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 28: Number of Days Approved
Enter the number of days for which the PA was approved by the STAT-PA system.

SECTION VI – ADDITIONAL INFORMATION

Element 29
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.