FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR WAKIX 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. 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 Wakix form, F-02573. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Wakix form to request PA for Wakix 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 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 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 check 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
Note: A copy of the member's current medical records that support a clinical correlation between the member's test results and the member's condition of excessive daytime sleepiness (EDS) associated with narcolepsy needs to be submitted with the PA request, including the following:

- Test results and provider interpretation for the overnight polysomnogram and multiple sleep latency test (MSLT)
- A copy of the Epworth sleepiness scale questionnaire, maintenance of wakefulness test, or MSLT confirming that the member has EDS
- For renewal requests, medical record documentation demonstrating clinical improvement, including a decrease in the member's EDS, which is supported by an Epworth sleepiness scale questionnaire, maintenance of wakefulness test, or MSLT

Element 13: 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 14
Check the appropriate box to indicate whether or not the member has narcolepsy.

Element 15
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 16
Check the appropriate box to indicate whether or not the prescriber has reviewed the member's current medication list to evaluate for potential drug interactions (for example, cytochrome P450 2D6 [CYP2D6] inhibitors, cytochrome P450 3A4 [CYP3A4] inducers, and drugs that increase the QT interval).

Element 17
Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

Element 18
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. Also 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.

Element 19
Check the appropriate box to indicate whether or not the member has had an overnight polysomnogram sleep study followed by an MSLT.

Element 20
Check the appropriate box to indicate whether or not the member has EDS that interferes with normal activities on a daily basis.

Element 21
Check the appropriate box to indicate whether or not the member completed an Epworth sleepiness scale questionnaire, maintenance of wakefulness, or MSLT.

Element 22
Check the appropriate box to indicate whether or not the prescriber has ruled out or treated the member for each of the following potential causes of EDS:

- Other sleep disorders including sleep apnea
- Chronic pain or illness that disrupts normal sleep patterns
- Mood disorders such as depression
- Caffeine or nicotine use causing poor quality of nighttime sleep

Element 23
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant. If yes, list the stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the stimulant was taken in the space provided.

Element 24
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents treatment with a stimulant. If yes, list the medical condition(s) that prevents treatment with a stimulant in the space provided.

Element 25
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and stimulants. If yes, list the medication(s) and interaction(s) in the space provided.

Element 26
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response after the medication has been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with armodafinil or modafinil. If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates armodafinil or modafinil was taken in the space provided.

Element 27
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents treatment with armodafinil or modafinil. If yes, list the medical condition(s) that prevents treatment with armodafinil or modafinil in the space provided.

Element 28
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 or modafinil. If yes, list the medication(s) and interaction(s) in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

Element 29: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 30: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 31
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.