FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEADACHE AGENTS, PREVENTATIVE TREATMENT 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. 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 Headache Agents, Preventative Treatment, F-02667. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Headache Agents, Preventative Treatment 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 PA 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

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

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

Element 11: Phone Number – Prescriber
Enter the phone number, including the area code, of the prescriber.

Element 12: National Provider Identifier – Prescriber
Enter the 10-digit National Provider Identifier 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 Headache Agents, Preventative Treatment form.

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.

Note: A copy of the member's medical records must be submitted with all PA requests for non-preferred headache agents, preventative treatment drugs. Medical records must demonstrate that the member meets the clinical criteria and document the member's medical work-up for migraines, including the current number of headache days per month, the number of migraine days per month, the average migraine duration (in hours), as well as complete problem and medication lists.

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 migraines, with or without aura, according to the International Classification of Headache Disorders, 3rd edition, diagnostic criteria.

Element 16
Document the member's current headache frequency. Record the number of the member's headache days per month, migraine days per month, and the average migraine duration in hours.

Element 17
In the spaces provided, document the member's current migraine prescribed medication treatment regimen. List the current prescribed migraine preventative medications (drug name[s], dose, and dosing frequency), **including Botox (if applicable)**. List the current prescribed migraine rescue medications (drug name[s], dose, and dosing frequency).

Element 18
Check the appropriate box to indicate whether or not the member has taken Ajovy for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes is checked, indicate the dose, the approximate dates taken, and the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Element 19
Check the appropriate box to indicate whether or not the member has taken Emgality 120 mg for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes is checked, indicate the dose, the approximate dates taken, and the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY

Element 20
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 and/or a decrease in migraine duration compared to their baseline prior to initiation of treatment with a headache agent, preventative treatment drug.

Element 21
Document the member's current headache frequency. Record the number of the member's headache days per month, migraine days per month, and the average migraine duration in hours.

Element 22
List the current prescribed migraine preventative medications (drug name[s], dose, and dosing frequency), **including Botox (if applicable)**. Also list the current prescribed migraine 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 migraine medication treatment regimen.

SECTION VI – AUTHORIZED SIGNATURE

Element 23: Signature – Prescriber
The prescriber is required to sign and date this form.

Element 24: Date Signed
Enter the date the form was signed in mm/dd/ccyy format.

SECTION VII – ADDITIONAL INFORMATION

Element 25
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested also may be included.