FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ORAL ULCERS ASSOCIATED WITH BEHCET'S DISEASE AND UVEITIS 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 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 PA for certain drugs. 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 PA request. Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

INSTRUCTIONS

Prescribers are required to complete, sign, and date the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form, F-03224. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form to request PA by submitting a PA request on the ForwardHealth Portal (the Portal), by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the PA 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 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

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

Element 10: Phone Number – Prescriber
Enter the phone number, including the area code, of the prescribing provider.

Element 11: National Provider Identifier – Prescriber
Enter the prescribing provider's National Provider Identifier.

SECTION III – CLINICAL INFORMATION (Required for All PA Requests)
Include diagnostic and clinical information explaining the need for the drug being requested. Complete all elements in Section III. Check Yes or No as it applies to each question. Include written documentation as indicated.

Element 12 – 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: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.

SECTION III A – CLINICAL INFORMATION FOR ORAL ULCERS ASSOCIATED WITH BEHCET'S DISEASE ONLY

Element 13
Check the appropriate box to indicate whether or not the member has oral ulcers associated with Behcet's disease.

Element 14
Check the appropriate box to indicate whether or not the prescription was written by a rheumatologist or through a rheumatology consultation.

Element 15
Check the appropriate box to indicate whether or not the member is currently using the requested non-preferred cytokine and CAM antagonist drug. If yes, indicate the approximate date therapy was started.

Element 16
Check the appropriate box to indicate whether or not the member has taken Otezla for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes, list the Otezla dose and the dates taken, and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. If additional space is needed, continue documentation in Section V of the form.

Element 17
Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR OTEZLA XR PA REQUESTS

Element 18
PA requests for Otezla XR must include detailed clinical justification for prescribing Otezla XR instead of Otezla. This clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead Otezla.

SECTION III C – CLINICAL INFORMATION FOR UVEITIS ONLY

Element 19
Check the appropriate box to indicate whether or not the member has uveitis.

Element 20
Check the appropriate box to indicate whether or not the prescription was written by an ophthalmologist or through an ophthalmology consultation.

Element 21
Check the appropriate box to indicate whether or not the member is currently using the requested non-preferred cytokine and CAM antagonist drug. If yes, indicate the approximate date therapy was started.

Element 22
Check the appropriate box to indicate whether or not the member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes, list the name and dose of the drug used and the dates taken, and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. If additional space is needed, continue documentation in Section V of the form.

Element 23
Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION III D – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED ADALIMUMAB-XXXX PA REQUESTS

Element 24
PA requests for a non-preferred adalimumab-xxxx drug must include detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. This clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

SECTION IV – AUTHORIZED SIGNATURE

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

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

SECTION V – ADDITIONAL INFORMATION

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