Prior Authorization Drug Attachment for Voquezna Tablets 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 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 Pharmacy service area of the ForwardHealth Online Handbook for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a determination about the request.

Instructions

Prescribers are required to complete, sign, and date the Prior Authorization Drug Attachment for Voquezna Tablets form, F-03384. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Voquezna Tablets 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 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 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 (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 name of the drug.

Element 5: Drug Strength
Enter the strength of the listed drug.

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 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 (required for all PA requests)

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

Element 13: 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.

Element 14
Indicate which medical condition Voquezna tablets are being prescribed to treat.

Element 15
Indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** proton pump inhibitors. If yes, list the drug names and

dates they were taken, and describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Section IV – Authorized signature

Element 16: Signature
The prescriber is required to complete and sign this form.

Element 17: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

Section V – Additional information

Element 18: Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the requested drug may be included here.