FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING
CYCLO-OXYGENASE INHIBITORS, COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information applies to Medicaid and SeniorCare.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stats. § 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 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 Non-steroidal Anti-inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, F-11077. Pharmacy providers are required to use the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors 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 or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call 800-947-1197.

2) For requests submitted on the ForwardHealth Portal, prescribers can access *www.forwardhealth.wi.gov/.*

3) For paper 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.

4) For paper 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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. 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 identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification 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

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

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 (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Providers are required to complete the appropriate sections before signing and dating the PA/PDL for NSAIDS, Including Cyclo-oxygenase Inhibitors, form. For PA requests for cyclo-oxygenase inhibitors, providers are also required to complete Section IIIA.

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.

Element 13
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred NSAIDs. (The two preferred NSAIDs taken cannot include ibuprofen or naproxen.) If yes, list the preferred NSAIDs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred NSAIDs were taken in the space provided.

SECTION IIIA — CLINICAL INFORMATION FOR CYCLO-OXYGENASE INHIBITORS ONLY

Element 14
Check the appropriate box to indicate whether or not the member has a history of familial adenomatous polyposis (FAP).

Element 15
Check the appropriate box to indicate whether or not the member has medical record documentation of thrombocytopenia or platelet dysfunction.

Element 16
Check the appropriate box to indicate whether or not the member has medical record documentation of peptic ulcer disease, a history of gastrointestinal (GI) bleeding, or a history of NSAID-induced GI bleeding.

Element 17
Check the appropriate box to indicate whether or not the member is currently taking oral anticoagulation therapy.

Element 18
Check the appropriate box to indicate whether or not the member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.

Element 19
Check the appropriate box to indicate whether or not the member is 65 years of age or older.

SECTION IV — 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.

Element 22 — NPI
Enter the NPI. 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 (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS 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 STAT-PA request was approved by the STAT-PA system.

SECTION V — 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 VI — ADDITIONAL INFORMATION

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