FORWARDHEALTH

PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

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 (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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. 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/Brand Medically Necessary Attachment (PA/BMNA), F-11083. Pharmacy providers are required to use the completed PA/BMNA to request PA for BMN drugs 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:

1) For requests submitted on the ForwardHealth Portal, pharmacy providers may access *www.forwardhealth.gov/*.

2) 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.

3) 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

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

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 — Prescriber
Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION

Element 12 — Diagnosis — Primary Code and/or Description
Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the drug or biologic requested. The ICD diagnosis code must correspond with the ICD description.

Note: As required in DHS 107.10(3)(c), Wis. Admin. Code, when a prescription is for a BMN drug, the prescriber is required to write "brand medically necessary" in his or her own handwriting. This required statement may be handwritten either directly on the prescription or on a separate order attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. Blanket authorization for an individual member, drug, or prescriber is not acceptable documentation.

Element 13
Check the appropriate box to indicate whether or not "brand medically necessary" is handwritten by the prescriber on the prescription or on a separate order attached to the original prescription.

Element 14
Check the appropriate box to indicate whether or not the brand medically necessary request is for one of the following drugs:

- Anticonvulsant used to treat a seizure disorder.
- Cellcept.
- Coumadin.
- Neoral.
- Prograf.

If yes was indicated, skip Elements 15-17 and proceed to Elements 18-19.

Element 15
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with at least two different manufacturers of the generic equivalent drug. If yes, list the manufacturer or National Drug Code (NDC) and the dates the drug was taken. Indicate the specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) that can be directly attributed to the generic equivalent drugs in the space provided.

Note: Pharmacy providers may provide manufacturer or NDC and dates taken.

Element 16
Explain in the space provided how the BMN drug will prevent the recurrence of the unsatisfactory therapeutic response or clinically significant adverse drug reaction described in Element 15.

Element 17
Check the appropriate box to indicate whether or not the member has taken the requested brand name drug and had a measurable therapeutic response. If yes, indicate the approximate dates the brand name drug was taken.

SECTION IV — AUTHORIZED SIGNATURE

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/BMNA was signed by the prescriber.

SECTION V — ADDITIONAL INFORMATION

Element 20
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug required may be included.