

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.

Prescribers are required to complete and sign the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083, and send it to the pharmacy provider where the prescription will be filled. Pharmacy providers are required to attach the completed PA/BMNA to a Prior Authorization Request Form (PA/RF), F-11018, and a copy of the prescription and send the forms to ForwardHealth. Prescribers and dispensing providers are required to retain a completed copy of the form.

Pharmacy providers may submit PA requests to ForwardHealth by fax at (608) 221-8616 or by mail 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 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 3 — 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.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name

Enter the drug name.

Element 5 — Strength(s)

Enter the strength(s) of the drug listed in Element 4.

Element 6 — National Drug Code

Enter the appropriate 11-digit National Drug Code.

Element 7 — Date Prescription Written

Enter the date the prescription was written.

Element 8 — Directions for Use

Enter the directions for use of the drug.

Element 9 — Start Date Requested

Enter the start date requested for PA.

Element 10 — Name — Prescriber

Enter the name of the prescriber.

Element 11 — National Provider Identifier

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

Element 12 — Address — Prescriber

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

Element 13 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 14

Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

SECTION III — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. Documentation must indicate how the brand name drug will prevent recurrence of an adverse or allergic reaction, or a therapeutic failure, with the generic drug. In Elements 16 through 21, check "yes" to all that apply.

Element 15 — Diagnosis — Primary Code and/or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 16

Check the appropriate box to indicate whether or not the member has experienced an adverse reaction to the generic equivalent drug. If yes, indicate the adverse drug reaction that can be directly attributable to the generic equivalent drug and the approximate dates the drug was taken.

Element 17

Check the appropriate box to indicate whether or not the member has experienced a treatment failure of the generic equivalent drug. If yes, indicate the treatment failure and the approximate dates the drug was taken.

Element 18

Check the appropriate box to indicate whether or not the member has experienced an allergic reaction to the generic equivalent drug and whether or not the provider anticipates that the brand name drug will not cause the same allergic reaction. If yes, indicate the allergic reaction and the approximate dates the drug was taken, if known.

Element 19

Explain how the brand medically necessary drug will prevent the recurrence of the adverse reaction, treatment failure, or allergic reaction described in responses to Elements 16, 17, and 18.

Element 20

Check the appropriate box to indicate whether or not the member has a medical condition that causes a contraindication to the use of the generic equivalent drug. If yes, indicate the medical condition and why or how the condition impacts the use of the generic equivalent drug.

SECTION III — CLINICAL INFORMATION FOR NARROW THERAPEUTIC INDEX DRUGS

Element 21 — For the Following Drugs Only: Any Brand Name Anticonvulsant Drug Used to Treat a Seizure Disorder, Clozaril, Coumadin, Neoral, or Prograf

Check the appropriate box to indicate whether or not the member's past medical history suggests an anticipated treatment failure with a generic equivalent drug. If yes, indicate the prescriber's documentation of the anticipated therapeutic failure and the past medical history that forms the basis of the anticipated therapeutic failure.

Element 22 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 23 — Date Signed

Enter the month, day, and year the PA/BMNA was signed.

SECTION IV — ADDITIONAL INFORMATION

Element 24

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