

**FORWARDHEALTH
PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA) 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, but is not limited to, information concerning enrollment status, accurate name, address, and member ID.

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 a PA for certain drugs. 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, sign, and date the Prior Authorization/Drug Attachment (PA/DGA) form. Pharmacy providers may submit the PA/DGA form 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 in one of the following ways:

- For PA requests submitted on the Portal, pharmacy providers may access www.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 to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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: Refills

Enter the amount 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 prescribing provider.

Element 11: Phone Number – Prescriber

Enter the phone number, including area code, of the prescribing provider.

Element 12: National Provider Identifier – Prescriber

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

SECTION III – CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/DGA form.

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.

SECTIONS IV–VIII

Complete the appropriate sections of this form:

- Section IV for HealthCheck “Other Services” drug requests
- Section V for diagnosis-restricted drug requests
- Section VI for drugs with specific PA criteria addressed in the ForwardHealth Online Handbook
- Section VII for other drug requests
- Section VIII for additional information when extra space is needed to complete Sections IV–VII

SECTION IV – CLINICAL INFORMATION FOR HEALTHCHECK “OTHER SERVICES” DRUG REQUESTS

Element 14

If the prescriber writes a prescription for a drug that is not covered under the member's ForwardHealth benefit plan, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested through a HealthCheck “Other Services” PA request. Documentation of the drug name, quantity, dose, duration of therapy, previous treatments, and detailed reasons why other covered drug treatments were discontinued or not used is required. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

Note: HealthCheck “Other Services” is limited to members under 21 years of age.

SECTION V – CLINICAL INFORMATION FOR DIAGNOSIS-RESTRICTED DRUG REQUESTS

Element 15

If the prescriber writes a prescription with a diagnosis outside the ForwardHealth-allowed diagnoses for a drug, the prescriber is required to attach peer-reviewed medical literature to support the proven efficacy and safety of the requested use of the drug. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used is required. Medical records should be provided as necessary to support the PA request.

SECTION VI – CLINICAL INFORMATION FOR DRUGS WITH SPECIFIC CRITERIA ADDRESSED IN THE FORWARDHEALTH ONLINE HANDBOOK

Element 16

If the prescriber writes a prescription for a drug that has specific criteria addressed in the ForwardHealth Online Handbook of the ForwardHealth Portal, the prescriber is required to review the Online Handbook criteria and document the required information. Refer to the Prior Authorization/Drug Attachment topic (#15937) of the Online Handbook for more information and a list of drugs.

SECTION VII – CLINICAL INFORMATION FOR OTHER DRUG REQUESTS

Element 17

If the prescriber writes a prescription for a drug that requires the use of the PA/DGA form and is not previously referenced in the above sections, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used is required. In addition, if the drug requested is a non-preferred Preferred Drug List (PDL) drug, prescribers are required to specifically address why other preferred PDL drugs cannot be used. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

Note: If the pharmacy submitting the PA request is an out-of-state pharmacy providing a non-emergency service and the drug being requested does not have specific PA criteria established, additional documentation is required to be submitted. PA documentation must demonstrate that the member has a medical condition for which the requested drug has Food and Drug Administration (FDA) approval (medical records must be provided to verify the member's medical condition). Additionally, the drug must be prescribed in a dose and manner consistent with the FDA-approved product labeling.

SECTION VIII – ADDITIONAL INFORMATION

Element 18

Indicate any additional information in the space provided. If the space provided in Sections IV–VII is not sufficient, use Section VIII to include any additional information.

SECTION IX – AUTHORIZED SIGNATURE

Element 19: Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 20: Date Signed

Enter the month, day, and year the form was signed in mm/dd/ccyy format.