

FORWARDHEALTH
**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION
MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIASIS 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 number.

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only 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. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis, F-11306. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form to request PA 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 drug attachment form in one of the following ways:

- For requests submitted on the ForwardHealth 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 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 drug attachment form 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

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 – Prescriber

Enter the prescribing provider's National Provider Identifier.

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 the area code, of the prescribing provider.

SECTION III – CLINICAL INFORMATION FOR PSORIASIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

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.

Note: A copy of the member's medical records must be submitted with the PA request to support the condition being treated, details regarding previous medication use, and outline the member's current treatment plan.

Element 13

Check the appropriate box to indicate whether or not the member has psoriasis. If yes, indicate the areas affected and the approximate percent of body surface area involved.

Element 14

Check the appropriate box to indicate whether or not the prescription was written by a dermatologist or through a dermatology consultation.

Element 15

Check the appropriate box to indicate whether or not the member is currently using the requested cytokine and CAM antagonist drug. If yes, indicate the approximate date therapy was started.

Element 16

Check the appropriate box to indicate whether or not the member has attempted any of the following drugs or therapies for psoriasis: cyclosporine, methotrexate, phototherapy, or acitretin. If yes, indicate the drug or therapy name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section V of the form.

Element 17

Check the appropriate box to indicate whether or not the member has attempted other drugs for psoriasis (for example, topicals, glucocorticoids, or IV immunomodulators such as infliximab). If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section V of the form.

Element 18

Indicate the cytokine and CAM antagonist drug(s) the member has taken, dose, dates taken, reason for discontinuation, and specific details regarding the treatment response. If additional space is needed, continue documentation in Section V of the form.

Element 19

Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION IV – AUTHORIZED SIGNATURE

Element 20: Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 21: Date Signed

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

SECTION V – ADDITIONAL INFORMATION

Element 22

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