

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS 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 service.

Prior authorization requests for anti-obesity drugs submitted on paper require the use of this form. 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 Drug Attachment for Anti-Obesity Drugs form, F-00163, to request PA for anti-obesity drugs. Prescribers are required to retain a completed copy of the form.

Prescribers may submit PA requests on a PA drug attachment form in one of the following ways:

- 1) For requests submitted through the Drug Authorization and Policy Override Center, prescribers may call (800) 947-9627.
- 2) For paper PA requests by fax, prescribers 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 paper PA requests by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment form to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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 AND PROVIDER 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.

Element 4 — Name — Prescriber

Enter the name of the prescribing provider.

Element 5 — National Provider Identifier (NPI) — Prescriber

Enter prescribing provider's National Provider Identifier (NPI).

Element 6 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

Element 8 — Name — Billing Provider

Enter the name of the billing provider. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on the PA request. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on the PA request.

Element 9 — NPI — Billing Provider

Enter billing provider's NPI.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name

Check the box with the name of the appropriate drug.

Element 11 — Drug Strength

Enter the strength of the drug listed in Element 10.

Element 12 — Date Prescription Written

Enter the date the prescription was written.

Element 13 — Directions for Use

Enter the directions for use of the drug.

Element 14 — Refills

Enter the number of refills.

SECTION III — CLINICAL INFORMATION

Element 15 — Diagnosis Code and Description

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

Element 16 — Height — Member

Enter the member's height in inches.

Element 17 — Weight — Member

Enter the member's weight in pounds.

Element 18 — Date Member's Weight Was Measured

Enter the date the member's weight was measured in MM/DD/CCYY format.

Element 19 — Body Mass Index (BMI) — Member

Enter the member's current body mass index (BMI) using the following equation.

$$\text{BMI} = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$$

Example: Height = 5'9"

Weight = 230 lbs

Figure out height in inches: $5 \times 12 = 60 + 9 = 69$

$$\text{BMI} = \frac{703 \times 230}{69^2}$$

$$\text{BMI} = \frac{161690}{4761}$$

$$\text{BMI} = 33.96$$

Element 20 — Goal Weight — Member

Enter the member's goal weight in pounds. This should be a number agreed upon by the prescribing medical practitioner and the member.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

Complete this section for initial and renewal requests for anti-obesity drugs.

Element 21

Indicate whether or not the member is pregnant or nursing.

Element 22

Indicate whether or not the member has a history of an eating disorder (e.g., anorexia, bulimia).

Element 23

Indicate the medication prescribed for the member. In addition, answer the questions below the drug name that apply to the member's medical history.

SECTION IV B — INITIAL COVERAGE REQUIREMENTS

Complete this section for initial requests for anti-obesity drugs.

Element 24

Indicate whether or not the member's BMI is greater than or equal to 30 or greater than or equal to 27 but less than 30 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, or type II diabetes mellitus. If applicable, indicate the member's current risk factors.

Element 25

Indicate whether or not the member has participated in a weight loss treatment plan in the past six months and if the member will continue to follow the treatment plan while taking an anti-obesity drug. If yes, describe the treatment plan.

SECTION V — AUTHORIZED SIGNATURE

Element 26 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 27 — Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 28

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

SECTION VII — INTERNAL USE ONLY

This section is for internal use only.