

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR PROVIGIL® AND NUVIGIL® 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 a 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.

Attach the completed Prior Authorization Drug Attachment for Provigil® and Nuvigil® form, F-00079, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail 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).

Note: Nuvigil® is not covered by the BadgerCare Plus Core Plan for Adults with No Dependent Children.

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

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

SECTION II — PRESCRIPTION INFORMATION

Providers should check only the name and strength of the drug for which PA is being requested.

Element 4 — Provigil® Drug Strength

Check the strength of drug in milligrams.

Element 5 — Nuvigil® Drug Strength

Check the strength of drug in milligrams.

Element 6 — Date Prescription Written

Enter the date that the prescription was written.

Element 7 — Refills

Enter the number 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 — Prescriber National Provider Identifier

Enter the 10-digit National Provider Identifier of the prescriber.

Element 11 — Address — Prescriber

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

Element 12 — Telephone Number — Prescriber

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

SECTION III — CLINICAL INFORMATION

Providers are required to complete Section III and either Section III A, III B, III C, or III D before signing the form.

Element 13 — Diagnosis Code and Description

Enter the appropriate *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 14

Indicate whether or not the member is at least 16 years old.

Element 15

Indicate whether or not the member is currently taking any other stimulants.

Element 16

For requests for Nuvigil®, indicate whether or not the member has tried and failed or had a significant adverse drug reaction to Provigil®. If yes is checked, provide the dose of Provigil® tried, the dates it was taken, and the reason(s) for discontinuation.

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY

Element 17

Indicate whether or not the member has a diagnosis of Narcolepsy.

Element 18

Indicate whether or not the member has completed a polysomnogram (PSG). If yes, the results from a PSG **must** be submitted with this PA request for consideration.

Element 19

Indicate whether or not the member has taken a Multiple Sleep Latency Test (MSLT). If yes, the results from an MSLT **must** be submitted with this PA request for consideration.

SECTION III B — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME

Element 20

Indicate whether or not the member has a diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS).

Element 21

Indicate whether or not the member has completed a polysomnogram (PSG). If yes, the results from a PSG **must** be submitted with this PA request for consideration.

Element 22

Indicate the member's Apnea-Hypopnea Index (AHI) in events per hour.

Element 23

Indicate whether or not the member has tried Continuous Positive Airway Pressure (CPAP).

SECTION III C — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

Element 24

Indicate whether or not the member has a diagnosis of shift work sleep disorder.

Element 25

Indicate whether or not the member is a night-shift worker.

Element 26

Indicate whether or not the member is taking any hypnotics, sleep aids, or other medications that can cause sleepiness.

Element 27

Enter the member's current employer, along with his or her weekly work schedule.

SECTION III D — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (PROVIGIL® ONLY)

Element 28

Indicate whether or not the member has a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).

Element 29

Indicate whether or not the member has a medical history of substance abuse or misuse. If yes, explain the substance abused and the current state of the member's usage of that substance. Also include any rehabilitation taken.

Element 30

Indicate whether or not the member poses a risk of drug diversion. If yes, explain what the member has done in the past to be considered a risk for diversion.

Element 31

For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, indicate whether or not the member has experienced treatment failures or clinically significant adverse drug reactions with two or more preferred stimulants. If yes, list the stimulants tried, dates taken, and reasons for discontinuation.

Element 32

For members enrolled in the Core Plan, indicate whether or not the member has experienced treatment failures or clinically significant adverse drug reactions with two or more generic stimulants. If yes, list the stimulants tried, dates taken, and reasons for discontinuation.

SECTION IV — AUTHORIZED SIGNATURE

Element 33 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 34 — Date Signed

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

SECTION V — ADDITIONAL INFORMATION

Element 35

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