

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BYETTA AND SYMLIN 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 Byetta and Symlin form, F-00080, 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).

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

Element 4 — Drug Name and Strength

Check the name and strength of drug.

Element 5 — Date Prescription Written

Enter the date that the prescription was written.

Element 6 — Directions for Use

Enter the directions for use of the drug.

Element 7 — Name — Prescriber

Enter the name of the prescriber.

Element 8 — Prescriber National Provider Identifier

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

Element 9 — Address — Prescriber

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

Element 10 — 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 or III B before signing and dating the form.

Element 11 — 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 12

Enter member's last Hemoglobin A1c (HbA1c) test results.

Element 13 — Date Member's HbA1c Measured

Enter the date of the HbA1c test from Element 12.

Element 14

Indicate whether or not the member is using the medication for weight loss.

Element 15

Indicate whether or not the member is currently using Byetta.

Element 16

Indicate whether or not the member is currently using Symlin.

SECTION III A — CLINICAL INFORMATION FOR BYETTA®

Element 17

Indicate whether or not the member has a diagnosis of Type II Diabetes.

Element 18

Indicate whether or not the member is at least 18 years old.

Element 19

Indicate whether or not the member is currently taking a sulfonylurea. If yes, indicate the drug name, dose, and directions for use.

Element 20

Indicate whether or not the member was unable to tolerate the maximum dose of a sulfonylurea due to a clinically significant adverse drug reaction. If yes, list the drug name, the dose the member was able to titrate to, and the adverse reaction that occurred.

Element 21

Indicate whether or not the member has failed to achieve adequate glycemic control at the maximum dose of a sulfonylurea. If yes, indicate the drug on which the member failed, the dose, and directions for use.

Element 22

Indicate whether or not the member is currently taking metformin. If yes, indicate the dose and directions for use.

Element 23

Indicate whether or not the member is unable to tolerate the maximum dose of metformin due to a clinically significant adverse drug reaction. If yes, list the dose the member was able to titrate to, and the adverse reaction that occurred.

Element 24

Indicate whether or not the member has failed to achieve adequate glycemic control at the maximum dose of metformin. If yes, indicate the dose and directions for use.

Element 25

Indicate whether or not the member is currently taking a thiazolidinedione. If yes, indicate the drug name, dose, and directions for use.

Element 26

Indicate whether or not the member is unable to tolerate the maximum dose of a thiazolidinedione due to a clinically significant adverse drug reaction. If yes, list the drug name, the dose the member was able to titrate to, and the adverse reaction that occurred.

Element 27

Indicate whether or not the member has failed to achieve adequate glycemic control at the maximum dose of a thiazolidinedione. If yes, indicate the drug on which the member failed, the dose, and directions for use.

SECTION III B — CLINICAL INFORMATION FOR SYMLIN®

Element 28

Indicate whether or not the member is currently taking insulin to control Type I Diabetes.

Element 29

Indicate whether or not the member is currently taking insulin to control Type II Diabetes.

Element 30

Indicate whether or not the member is at least 15 years old.

Element 31

Indicate whether or not the member is currently using an insulin pump.

Element 32

If the member is currently taking insulin, indicate each type of insulin he or she is taking and include the number of units and dosing frequency for each type.

Element 33

Indicate whether or not the member has gastroparesis.

Element 34

Indicate whether or not the member has hypoglycemia unawareness.

Element 35

Indicate whether or not the member has required emergency treatment for severe hypoglycemia in the past six months. If yes, list how many different occasions he or she required emergency treatment in the past six months.

SECTION IV — AUTHORIZED SIGNATURE

Element 36 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 37 — Date Signed

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

SECTION V — ADDITIONAL INFORMATION

Element 38

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