

**FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LOVAZA®
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 Lovaza® 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 Lovaza® form, F-00162, to request PA for Lovaza®. 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 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 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 the 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 the billing provider's NPI.

SECTION II — PRESCRIPTION INFORMATION

Element 10 — Drug Name

This element is populated with Lovaza[®].

Element 11 — Drug Strength

Enter the strength of the Lovaza[®] prescribed to the member.

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

Confirm that the information submitted in this section is the most current.

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

Enter the member's most recent lipid panel.

Element 17

Enter the date the member's most recent lipid panel was taken.

SECTION IV — INITIAL COVERAGE REQUIREMENTS

Element 18

Indicate whether or not the member has an allergy or sensitivity to fish.

Element 19

Indicate whether or not the member has a medical condition (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia.

Element 20

Indicate whether or not the member is taking a medication (e.g., beta blocker, thiazide, estrogen) that may contribute to hypertriglyceremia.

Element 21

Indicate whether or not the prescriber has evaluated and discussed lifestyle changes (e.g., diet, exercise, weight loss, alcohol consumption) with the member that may improve triglyceride levels.

Element 22

List the member's current lipid- and triglyceride-lowering therapies, including all medication names, daily doses, and start dates.

Element 23

Indicate whether or not the member's triglyceride level has been 500 mg/dL or greater in the past five years. If yes, enter the triglyceride level and date of the test.

SECTION V — AUTHORIZED SIGNATURE

Element 24 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 25 — Date Signed

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

SECTION VI — ADDITIONAL INFORMATION

Element 26

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.