**FORWARDHEALTH**
# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR OPIOID DEPENDENCY AGENTS – BUPRENORPHINE 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 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 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 on 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. Attach additional pages if more space is needed. Refer to the Pharmacy service area of the ForwardHealth Online Handbook 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, sign, and date the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents–Buprenorphine form, F-00081. Pharmacy providers are required to use the PA/PDL for Opioid Dependency Agents–Buprenorphine form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or 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 PA/PDL form in one of the following ways:

- For STAT-PA requests, pharmacy providers should call 800-947-1197.
- For PA requests submitted on the Portal, pharmacy providers may access https://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 PA/PDL form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI  53784

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 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

**Element 4: Drug Name**
Enter the name of the prescribed drug.

**Element 5: Drug Strength**
Enter the strength(s) of the drug prescribed 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: Address – Prescriber**
Enter the address (street, city, state, and zip+4 code) of the prescriber.

**Element 11: Phone Number – Prescriber**
Enter the phone number, including area code, of the prescriber.

**Element 12: National Provider Identifier (NPI) – Prescriber**
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

## SECTION III – CLINICAL INFORMATION (Required for All PA Requests)
Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL for Opioid Dependency Agents–Buprenorphine form.

**Element 13: Diagnosis Code and Description**
Enter the appropriate 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. The diagnosis code indicated must be an allowable diagnosis code for opioid dependency agents–buprenorphine.

**Element 14**
Check the appropriate box to indicate whether or not the member is 16 years of age or older.

**Element 15**
Check the appropriate box to indicate whether or not the member is taking any other opioids, tramadol, or carisoprodol. If yes, list the drugs taken and the dates they have been taken in the space provided.

**Element 16**
Check the appropriate box to indicate whether or not the member is pregnant. If yes, indicate the member's expected delivery date in mm/dd/ccyy format.

**SECTION IV – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED BUPRENORPHINE-NALOXONE DRUG REQUESTS (PA requests for non-preferred buprenorphine-naloxone drugs may not be submitted via STAT-PA.)**

**Element 17**
Provide detailed clinical justification for prescribing a non-preferred buprenorphine-naloxone drug instead of buprenorphine-naloxone tablets, Suboxone film, and Zubsolv. Include clinical information why the member cannot use buprenorphine-naloxone tablets, Suboxone film, and Zubsolv and why it is medically necessary that the member receive a non-preferred buprenorphine-naloxone drug instead of buprenorphine-naloxone tablets, Suboxone film, and Zubsolv in the space provided.

**SECTION V – AUTHORIZED SIGNATURE**

**Element 18: Signature – Prescriber**
The prescriber is required to complete and sign this form.

**Element 19: Date Signed**
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

**SECTION VI – FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 20: National Drug Code**
Enter the appropriate 11-digit National Drug Code for each drug.

**Element 21: Days' Supply Requested (Up to 183 Days)**
Enter the requested days' supply.

**Element 22: NPI**
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

**Element 23: Date of Service (DOS)**
Enter the requested first date of service (DOS) for the drug in mm/dd/ccyy format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 24: Place of Service**
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

| Code | Description |
|------|-------------|
| 01 | Pharmacy |
| 13 | Assisted living facility |
| 14 | Group home |
| 32 | Nursing facility |
| 34 | Hospice |
| 50 | Federally qualified health center |
| 65 | End-stage renal disease treatment facility |
| 72 | Rural health clinic |

**Element 25: Assigned PA Number**
Enter the PA number assigned by the STAT-PA system.

**Element 26: Grant Date**
Enter the date the PA was approved by the STAT-PA system.

**Element 27: Expiration Date**
Enter the date the PA expires as assigned by the STAT-PA system.

**Element 28: Number of Days Approved**
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION VII – ADDITIONAL INFORMATION**

**Element 29**
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.