FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, OMEGA-3 ACIDS 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 service.

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 Drug Attachment for Lipotropics, Omega-3 Acids form, F-00162. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form to request PA 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 PA form.

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

- For PA requests submitted on the Portal, pharmacy providers can access 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 drug attachment to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA drug attachment to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  313 Blettner Blvd
  Madison WI 53784

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 drug name.

Element 5: Drug Strength
Enter the strength of the drug listed in Element 4.

Element 6: Date Prescription Written
Enter the date the prescription was written.

Element 7: Directions for Use
Enter the directions for use of the drug.

Element 8: Name – Prescriber
Enter the name of the prescribing provider.

Element 9: National Provider Identifier – Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier.

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.

SECTION III – CLINICAL INFORMATION (Required for All PA Requests)
Prescribers are required to complete Section III and either Section III A or Section III B before signing and dating the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form.

Element 12: Diagnosis Code and Description
Enter the appropriate and most specific 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.

Note: A copy of the member's current lipid panel report within the past 30 days must be submitted with all PA requests.

Element 13
Enter the member's current lipid panel, including the date the panel was taken, total cholesterol, high-density lipoprotein (HDL) cholesterol, low-density lipoprotein (LDL) cholesterol, and triglyceride levels in the space provided.

Note: For severe hypertriglyceridemia use (500 mg/dL or greater), **complete Section III A**. For atherosclerotic cardiovascular disease (ASCVD) risk reduction use, **complete Section III B.**

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR SEVERE HYPERTRIGLYCERIDEMIA USE (500 MG/DL OR GREATER)

Element 14
Check the appropriate box to indicate whether or not the member's triglyceride level has ever been 500 mg/dL or greater. If yes is checked, list the member's highest triglyceride level and test date in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member has taken the maximum dose of a preferred omega-3 acid **for at least three consecutive months** and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction. If yes is checked, provide the name of the preferred lipotropics, omega-3 acid taken and the dates the preferred lipotropics, omega-3 acid was taken. Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR ASCVD RISK REDUCTION USE

Element 16
Check the appropriate box to indicate whether or not the member is currently taking a maximized statin regimen. If yes is checked, list the member's current maximized statin regimen, including the drug name, drug strength, dosing regimen, and start date. Check the appropriate box to indicate whether or not the member has taken the maximized statin regimen **for at least three consecutive months** with failure to reach a triglyceride level of less than 150 mg/dL. Check the appropriate box to indicate whether or not the member will continue to take the maximized statin regimen along with the requested non-preferred lipotropics, omega-3 acid.

Element 17
Check the appropriate box to indicate whether or not the member has clinical ASCVD. If yes is checked, check all of the boxes that apply to the member's condition.

Element 18
Check the appropriate box to indicate whether or not the member has diabetes mellitus. If yes is checked, check the appropriate boxes to indicate that the member has any of the stated ASCVD risk factors. Check all risk factors that apply.

SECTION IV – AUTHORIZED SIGNATURE

Element 19: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 20: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 21
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.