FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HYPOGLYCEMICS, GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS 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 Hypoglycemics, Glucagon-Like Peptide (GLP-1) Agents form, F-00238, to request PA for non-preferred hypoglycemics, GLP-1 agents. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Hypoglycemics, GLP-1 Agents 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.

Pharmacy 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 may 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 form 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 form 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 name of the drug.

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: 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 – Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

SECTION III – CLINICAL INFORMATION
Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Hypoglycemics, GLP-1 Agents form.

Element 13: 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: Supporting clinical information, a copy of the member's current medical records, and a current hemoglobin A1c (HbA1c) lab report must be submitted with all PA requests.

Element 14
Check the appropriate box to indicate whether or not the non-preferred drug is being prescribed in a manner consistent with the Food and Drug Administration-approved product labeling.

Element 15
Check the appropriate box to indicate whether or not the member has type 2 diabetes mellitus.

Element 16
Indicate the member's most recent HbA1c.

Element 17
Indicate the date the member's most recent HbA1c was measured in mm/dd/ccyy format. The member's most recent HbA1c measurement must be within the past six months.

Element 18
Indicate the drug name, dose, and start date of the member's current hypoglycemics, GLP-1 therapy. Check None if appropriate.

Element 19
Check the appropriate box to indicate whether or not the member has taken the maximum dose of **at least one** preferred hypoglycemics, GLP-1 agent(s) for at least three consecutive months and experienced an unsatisfactory therapeutic response in glycemic control or experienced a clinically significant adverse drug reaction.

If yes, indicate the preferred hypoglycemics, GLP-1 agent(s) the member has taken and provide specific details regarding the member's unsatisfactory therapeutic response in glycemic control or clinically significant adverse drug reaction. The drug dose, approximate date(s) taken, and the reason(s) for discontinuing must also be documented.

SECTION IV – AUTHORIZED SIGNATURE

Element 20: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 21: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 22
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.