FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS INSTRUCTIONS

ForwardHealth requires certain information 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, but is not limited to, 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 only 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 PA for certain drugs. 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 Hepatitis C Agents form, F-01247. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Hepatitis C 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 form.

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

- For requests submitted on the ForwardHealth 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 form to ForwardHealth at 608-221-8616.
- For PA requests 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 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 Enrollment Verification System do not match, use the spelling from the Enrollment Verification System.

Element 2: Member ID Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the Enrollment Verification System 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: Date Prescription Written

Enter the date the prescription was written.

Element 5: Name – Prescriber
Enter the name of the prescribing provider.

Element 6: National Provider Identifier – Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier.

Element 7: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescriber.

Element 8: Phone Number – Prescriber
Enter the phone number, including area code, of the prescriber.

Element 9
Indicate the drug name, daily dose, and expected duration for the proposed hepatitis C drug treatment regimen. Indicate whether or not the member is currently taking the drug. If the member is currently taking this drug, enter the date started.

SECTION III – CLINICAL INFORMATION

Element 10: Diagnosis Code and Description
Enter the appropriate and most specific International Classification of Diseases diagnosis code and description most relevant to the drug requested. The International Classification of Diseases diagnosis code must correspond with the International Classification of Diseases description.

Note: A copy of the member's medical records that document the following must be submitted with the PA request:
- Hepatitis C virus (HCV) assessment and treatment plan
- Current history and physical, including complete problem and medication list
- Lab tests performed (within the last **six months**): albumin, complete blood count, international normalized ratio, liver function panel, serum creatinine, and HCV-ribonucleic acid (HCV-RNA) level

Element 11
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another drug the member is taking and the preferred drugs. If yes is checked, list the drug(s) and the interaction(s) in the space provided.

Element 12
Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents the use of the preferred drugs. If yes is checked, list the medical condition(s), and describe how the condition(s) prevents the member from using the preferred drug(s) in the space provided.

Element 13
Provide the date (in mm/dd/ccyy format) that the member was diagnosed with HCV, and indicate the likely source of the HCV infection.

Element 14
Indicate the member's HCV genotype and subtype and the HCV-RNA level and the date(s) performed.

Note: A copy of the lab results **must** be submitted with the PA request.

Element 15
Indicate the member's previous HCV treatment. Check the appropriate box to indicate whether or not the member has had previous pegylated interferon/ribavirin treatment or direct-acting antiviral HCV treatment. If the member has received previous HCV treatment, provide the drug name, date(s) taken, and treatment results.

Element 16
Check the appropriate box to indicate whether or not the member has had a liver biopsy, imaging studies, or blood assay tests to determine hepatic fibrosis. If yes, list the test performed, fibrosis stage, and date the test was performed in the spaces provided.

Note: A copy of the results **must** be submitted with the PA request.

Element 17
Check the appropriate box to indicate whether or not the member has cirrhosis. If yes, complete Section III A of the form.

SECTION III A – CLINICAL INFORMATION REQUIRED FOR MEMBERS WITH CIRRHOSIS ONLY

Element 18
If the member has cirrhosis, indicate the member's current Child-Turcotte-Pugh class, score, and the date calculated.

Element 19
Check the appropriate box to indicate whether or not the member has or is being treated for ascites, hepatic encephalopathy, hepatocellular cancer, or portal hypertension.

Element 20
Check the appropriate box to indicate whether or not the member has had medical imaging to screen for hepatocellular carcinoma within the last six months.

Note: A copy of the medical imaging results **must** be submitted with the PA request.

SECTION IV – AUTHORIZED SIGNATURE

Element 21: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 22: Date Signed
Enter the date the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 23
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.