

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HYPOGLYCEMICS, INSULINS LONG-ACTING 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 a 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

Submitting PA Requests

Pharmacy providers may submit PA requests on the Prior Authorization Drug Attachment for Hypoglycemics, Insulins Long-Acting 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 the Prior Authorization Request Form (PA/RF), F-11018, a copy of the member's current medical records, and the Prior Authorization Drug Attachment for Hypoglycemics, Insulins Long-Acting form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit the PA/RF, a copy of the member's current medical records, and the Prior Authorization Drug Attachment for Hypoglycemics, Insulins Long-Acting 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.

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 – ALL PA REQUESTS

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 and a copy of the member’s current medical records must be submitted with all PA requests.

Element 14

List the member’s current insulin treatment regimen and indicate the insulin name, dose/dose regimen, and start date. Check None if appropriate.

SECTION IV – CLINICAL INFORMATION – INITIAL PA REQUESTS ONLY

Elements 15a–b

Indicate whether or not the member has previously used insulin glargine U-100. If yes, provide details regarding how the member’s insulin glargine U-100 treatment regimen was adjusted to optimize glycemic control and approximate dates used. Include details regarding short-acting insulin if used in conjunction with insulin glargine U-100. In addition, provide details regarding the member’s hemoglobin A1c (HbA1c) and fasting blood glucose (FBG) readings along with approximate dates.

If the member has previously used insulin glargine U-100, indicate whether or not the member has experienced symptomatic hypoglycemia while using insulin glargine U-100. If yes, provide details regarding the frequency of hypoglycemic episodes, the blood sugar readings, when the last symptomatic hypoglycemic event occurred, and what medical intervention was required. Describe the insulin adjustment options that were utilized to decrease hypoglycemic episodes.

Elements 16a–b

List the glycemic treatment goals the prescriber has established for the member, such as HbA1c and FBG.

List the member's proposed insulin treatment regimen (insulin name and dose/dose regimen) to include the non-preferred hypoglycemics, insulins long-acting drug.

SECTION V – CLINICAL INFORMATION – RENEWAL PA REQUESTS ONLY

Element 17

Indicate whether or not the member has demonstrated a clinical improvement since starting the non-preferred hypoglycemics, insulins long-acting drug. If yes, provide specific examples of how the member's diabetes management has improved as a result of using a non-preferred hypoglycemics, insulins long-acting drug.

A copy of the member's medical records must be submitted that demonstrate an improvement in the member's glycemic control. Examples include a decrease in HbA1c, improved FBG, and decreased hypoglycemia.

SECTION VI – 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 VII – ADDITIONAL INFORMATION

Element 20

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