FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA), GIANT CELL ARTERITIS, NEONATAL ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID), AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA) 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, 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. Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

INSTRUCTIONS

Prescribers are required to complete, sign, and date the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Giant Cell Arteritis, Neonatal Onset Multisystem Inflammatory Disease (NOMID), and Non-Radiographic Axial Spondyloarthritis (nr-axSpA) form, F-01952. Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

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

- For PA requests submitted on the ForwardHealth Portal, providers may access www.forwardhealth.wi.gov.
- For PA requests 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

Providers and prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation. 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: 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 prescriber.

Element 9: Address – Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip+4 code.

Element 10: Phone Number – Prescriber
Enter the phone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 11: National Provider Identifier – Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

SECTION III – CLINICAL INFORMATION (Required for All Requests)
Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check Yes or No as it applies to each question. Include written documentation as indicated.

Element 12 – 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: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.

SECTION III A – CLINICAL INFORMATION FOR KINERET FOR DIRA ONLY

Element 13
Check the appropriate box to indicate whether or not the member has DIRA.

Element 14
Check the appropriate box to indicate whether or not the prescription is written by or through consultation with a DIRA specialist (for example, an immunologist or a rheumatologist).

Element 15
Check the appropriate box to indicate whether or not the member is currently using Kineret. If yes, indicate the approximate date therapy was started.

SECTION III B – CLINICAL INFORMATION FOR ACTEMRA FOR GIANT CELL ARTERITIS ONLY

Element 16
Check the appropriate box to indicate whether or not the member has giant cell arteritis.

Element 17
Check the appropriate box to indicate whether or not the prescription was written by a rheumatologist or through a rheumatology consultation.

Element 18
Indicate whether or not the member is currently using Actemra. If yes, indicate the approximate date therapy was started.

SECTION III C – CLINICAL INFORMATION FOR KINERET FOR NOMID ONLY

Element 19
Check the appropriate box to indicate whether or not the member has NOMID.

Element 20
Check the appropriate box to indicate whether or not the prescription was written by a rheumatologist or through a rheumatology consultation.

Element 21
Check the appropriate box to indicate whether or not the member is currently using Kineret. If yes, indicate the approximate date therapy was started.

SECTION III D – CLINICAL INFORMATION FOR NR-AXSPA ONLY

Element 22
Check the appropriate box to indicate whether or not the member has nr-axSpA.

Element 23
Check the appropriate box to indicate whether or not the prescription was written by a rheumatologist or through a rheumatology consultation.

Element 24
Check the appropriate box to indicate whether or not the member is currently using the requested non-preferred drug. If yes, indicate the approximate date therapy was started.

SECTION IV – AUTHORIZED SIGNATURE

Element 25: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 26: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 27
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.