FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, PROPROTEIN CONVERTASE SUBTILISIN / KEXIN TYPE 9 (PCSK9) INHIBITORS 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 PA for certain drugs. If necessary, 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, Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors form, F-02505. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Lipotropics, PCSK9 Inhibitors 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 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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. 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 the 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
Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Lipotropics, PCSK9 Inhibitors 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.

Element 14
Indicate the member's current low-density lipoprotein (LDL) in mg/dL.

Element 15: Date Member's LDL Measured
Enter the date the member's LDL was measured in mm/dd/ccyy format.

SECTION IV – CLINICAL INFORMATION – INITIAL PA REQUESTS ONLY
Note: Supporting clinical information and a copy of the member's current medical records must be submitted with initial PA requests. The supporting clinical information and medical records must include the following:

- Evidence that the member has heterozygous familial hypercholesterolemia (HeFH), homozygous familial hypercholesterolemia (HoFH), or clinical atherosclerotic cardiovascular disease (ASCVD)
- A current lipid panel lab report (HeFH and HoFH only)
- Documentation of the member's current and previous lipid lowering drug therapies, including the following for each trial:
  - Drug name(s) and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken) (HeFH and HoFH only)
  - Reasons for discontinuation if drug therapy was discontinued

Element 16
Check the applicable box to indicate which medical condition the PCSK9 inhibitor drug is being prescribed to treat. If clinical ASCVD is selected, check all of the boxes that apply to the member's condition.

Element 17
Document the member's current and previous lipid lowering drug therapies. For each trial, include the drug name(s) and dosage, dates taken, the lipid panel report prior to and during drug therapy with dates taken (HeFH and HoFH only), and reasons for discontinuation if drug therapy was discontinued.

SECTION V – CLINICAL INFORMATION – RENEWAL PA REQUESTS ONLY
Note: A copy of the member's current lipid panel (within the past 30 days) must be submitted with HeFH and HoFH renewal PA requests.

Element 18
Document the member's lipid lowering drug therapies. Include the name, dose, and dosing regimen for each drug.

SECTION VI – 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 VII – ADDITIONAL INFORMATION

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