

FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR WAKIX 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 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 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. If necessary, attach additional pages if more space is needed. 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 Wakix form, F-02573. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Wakix form to request PA for Wakix 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.

Pharmacy providers may submit PA requests in one of the following ways:

- For PA requests submitted on the ForwardHealth 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 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 (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

Providers should enter only the name and strength of the drug for which PA is being requested.

Element 4: Drug Name

Enter the name of the drug.

Element 5: Drug Strength

Enter the strength of the drug in milligrams.

Element 6: Date Prescription Written

Enter the date that the prescription was written.

Element 7: Directions for Use

Enter the directions for use of the drug.

Element 8: Refills

Enter the number of refills.

Element 9: Name – Prescriber

Enter the name of the prescriber.

Element 10: National Provider Identifier – Prescriber

Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

Element 11: Address – Prescriber

Enter the address (street, city, state, and zip+4 code) of the prescribing provider.

Element 12: Phone Number – Prescriber

Enter the phone number, including area code, of the prescribing provider.

SECTION III – CLINICAL INFORMATION

Note: A copy of the member's current medical records that support a clinical correlation between the member's test results and the member's medical condition of narcolepsy with cataplexy or narcolepsy without cataplexy must be submitted with the PA request, including the following:

- Test results and provider interpretation for the overnight polysomnogram (PSG) and Multiple Sleep Latency Test (MSLT)
- For members with excessive daytime sleepiness (EDS), a copy of the Epworth Sleepiness Scale (ESS) questionnaire, Maintenance of Wakefulness Test (MWT), or MSLT
- For renewal PA requests, medical record documentation demonstrating clinical improvement, including a decrease in cataplexy or a decrease in the member's EDS supported by an ESS questionnaire, MWT, or MSLT

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

Check the appropriate box to indicate whether or not the member has narcolepsy with cataplexy. If yes, indicate the cataplexy symptoms experienced by the member and how frequently they occur.

Element 15

Check the appropriate box to indicate whether or not the member has narcolepsy without cataplexy.

Element 16

Check the appropriate box to indicate whether or not the prescriber has reviewed the member's current medication list to evaluate for potential drug interactions (for example, cytochrome P450 2D6 [CYP2D6] inhibitors, cytochrome P450 3A4 [CYP3A4] inducers, and drugs that increase the QT interval).

Element 17

Check the appropriate box(es) to indicate which symptom(s) of narcolepsy Wakix is being used to treat.

Element 18

Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

Element 19

Check the appropriate box to indicate whether or not the member is taking central nervous system (CNS) depressants (for example, anxiolytics, barbiturates, or opioids). If yes, indicate the CNS depressants and daily doses in the spaces provided. Also indicate whether or not any of the listed CNS depressants contribute to the member's daytime sleepiness. If not, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

Element 20

Check the appropriate box to indicate whether or not the member has had an overnight PSG sleep study followed by an MSLT.

Element 21

Check the appropriate box to indicate whether or not the member has EDS that interferes with normal activities on a daily basis.

Element 22

Check the appropriate box to indicate whether or not the member completed an ESS questionnaire, an MWT, or an MSLT.

Element 23

Check the appropriate box to indicate whether or not the prescriber has ruled out or treated the member for each of the following potential causes of EDS:

- Other sleep disorders including sleep apnea
- Chronic pain or illness that disrupts normal sleep patterns
- Mood disorders such as depression
- Caffeine or nicotine use causing poor quality of nighttime sleep

Element 24

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant. If yes, list the stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the stimulant was taken in the space provided.

Element 25

Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents treatment with a stimulant. If yes, list the medical condition(s) that prevents treatment with a stimulant in the space provided.

Element 26

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

Element 27

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response after the medication has been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with armodafinil or modafinil. If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates armodafinil or modafinil was taken in the space provided.

Element 28

Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents treatment with armodafinil or modafinil. If yes, list the medical condition(s) that prevents treatment with armodafinil or modafinil in the space provided.

Element 29

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

Element 30

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or serotonin norepinephrine reuptake inhibitor (SNRI). If yes, list the TCA, SSRI, or SNRI, the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the TCA, SSRI, or SNRI was taken.

SECTION IV – AUTHORIZED SIGNATURE

Element 31: Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 32: Date Signed

Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 33

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