

FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stats. § 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 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 form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal or on paper. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call 800-947-1197.
- 2) For requests submitted on the ForwardHealth Portal, providers may access www.forwardhealth.wi.gov/.
- 3) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at 608-221-8616.
- 4) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL 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 identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification 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

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

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 — National Provider Identifier (NPI) — Prescriber

Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 10 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

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* (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

Element 13

Check the appropriate box to indicate whether or not the member has a diagnosis of psoriatic arthritis.

Element 14

Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of psoriatic arthritis.

Element 15

Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.

Element 16

Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of psoriatic arthritis.

Element 17

Check the appropriate box to indicate whether or not the member has received **two** or more of the drugs listed on the PA/PDL form for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, check the boxes next to the drugs the member received and indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted in paper.

Element 18

Check the appropriate box to indicate whether or not the member has taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. If yes, indicate the preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IV — 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 V — FOR PHARMACY PROVIDERS USING STAT-PA

Element 21 — National Drug Code

Enter the appropriate 11-digit National Drug Code for each drug.

Element 22 — Days' Supply Requested

Enter the requested days' supply, up to 365 days.

Element 23 — NPI

Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 24 — Date of Service

Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 25 — Place of Service

Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

| Code | Description |
|------|--|
| 01 | Pharmacy |
| 13 | Assisted living facility |
| 14 | Group home |
| 32 | Nursing facility |
| 34 | Hospice |
| 50 | Federally qualified health center |
| 65 | End-stage renal disease treatment facility |
| 72 | Rural health clinic |

Element 26 — Assigned PA Number

Enter the PA number assigned by the STAT-PA system.

Element 27 — Grant Date

Enter the date the PA request was approved by the STAT-PA system.

Element 28 — Expiration Date

Enter the date the PA expires as assigned by the STAT-PA system.

Element 29 — Number of Days Approved

Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 30

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