FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR OPIOID DEPENDENCY AGENTS 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 (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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 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/Preferred Drug List (PA/PDL) for Opioid Dependency Agents, F-00081. Pharmacy providers are required to use the PA/PDL for Opioid Dependency Agents 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, by fax, or by mail. 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 PA requests submitted 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 PA requests submitted 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).

Note: For members enrolled in the BadgerCare Plus Core Plan, PA requests for Suboxone® and buprenorphine must be submitted on the Portal or by fax or mail. For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, PA requests for Suboxone® and buprenorphine may be submitted using the STAT-PA system, the Portal, or by fax or mail.

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

Element 4 — Drug Name
Check the name of drug prescribed.

Element 5 — Drug Strength
Check the strength(s) of drug in milligrams.

Element 6 — Date Prescription Written
Enter the date that 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 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 11 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Prescribers are required to complete the appropriate sections before signing and dating the PA/PDL Opioid Dependency, Agents form.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis code indicated must be an allowable diagnosis code for Suboxone® or buprenorphine.

Element 14
Check the appropriate box to indicate whether or not the member is 16 years of age or older.

Element 15
Check the appropriate box to indicate whether or not the prescribing physician is a Drug Addiction Treatment Act (DATA 2000)-waived physician. If yes is checked, indicate the prescribing physician's "X" Drug Enforcement Administration (DEA) number in the space provided. Check no if the prescribing physician does not participate in this program.

Element 16
Check the appropriate box to indicate whether or not the member is taking any other opioids, tramadol, or carisoprodol. If yes is checked, list the drugs taken and the dates taken in the space provided.

Element 17
Check the appropriate box to indicate whether or not the member has any untreated or unstable psychiatric conditions that may interfere with compliance. If yes is checked, list the conditions in the space provided.

Element 18
Check the appropriate box to indicate whether or not the member is pregnant or nursing.

SECTION IV — ATTESTATION

The physician is required to read and sign the attestation statement for consideration of the PA request.

Element 19
Check the appropriate box to indicate whether or not the prescribing physician has read the attestation statement.

Element 20
Check the appropriate box to indicate whether or not the prescribing physician agrees to follow the guidelines set forth by State Medical Boards for opioid addiction treatment.

Element 21 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 22 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE TABLET REQUESTS

This section must be completed for pregnant or nursing women only.

Element 23
Check the appropriate box to indicate whether or not the member is pregnant.

Element 24
Check the appropriate box to indicate whether or not the member is nursing.

Element 25
Check the appropriate box to indicate whether or not the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant or nursing women.

Element 26
Check the appropriate box to indicate whether or not the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women.

SECTION VI — ADDITIONAL CLINICAL INFORMATION FOR BUPRENORPHINE-NALOXONE TABLET REQUESTS

Prior authorization requests for buprenorphine-nalaxone tablets must include clinical justification for prescribing buprenorphine-naloxone tablets instead of Suboxone® film.

Element 27
Provide detailed clinical information why the member cannot use Suboxone® film and why it is medically necessary that the member receive buprenorphine-naloxone tablets instead of Suboxone® film in the space provided.

SECTION VII — AUTHORIZED SIGNATURE

Element 28 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 29 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VIII — FOR PHARMACY PROVIDERS USING STAT-PA

Element 30 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 31 — Days' Supply Requested
Enter the requested days' supply.

Note: ForwardHealth will not approve a days' supply greater than 183 days.

Element 32 — NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 33 — 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 34 — 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 35 — Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 36 — Grant Date
Enter the date the PA was approved by the STAT-PA system.

Element 37 — Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 38 — Number of Days Approved
Enter the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION IX — ADDITIONAL INFORMATION

Element 39
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.