

FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, F-11075A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Directions for Use

8. Name — Prescriber

9. National Provider Identifier (NPI) — Prescriber

10. Address — Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

12. Diagnosis Code and Description

13. List the PDL drug class to which the requested non-preferred drug belongs (e.g., COPD agents).

Note: If applicable, prescribers may also complete Section IV of this form if the non-preferred drug belongs to one of the following drug classes: Alzheimer's Agents; Anticonvulsants; Antidepressants, Other; Antidepressants, SSRI; Antiparkinson's Agents; Antipsychotics; HIV-AIDS; or Pulmonary Arterial Hypertension.

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the preferred drugs from the same PDL drug class as the drug being requested?

Yes No

If yes, list the preferred drug(s) used. _____

List the dates the preferred drug(s) was taken. _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Continued



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SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and at least one of the preferred drugs from the same PDL drug class as the drug being requested? Yes No

If yes, list the drug(s) and interaction(s) in the space provided.

16. Does the member have a medical condition(s) that prevents the use of at least one of the preferred drugs from the same PDL drug class as the drug being requested? Yes No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred drug(s) in the space provided.

SECTION IV — ALTERNATE CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY (If applicable, prescribers may also complete this section.)

17. Indicate the drug class.

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's Agents | <input type="checkbox"/> Antiparkinson's Agents |
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Antipsychotics |
| <input type="checkbox"/> Antidepressants, Other | <input type="checkbox"/> HIV-AIDS |
| <input type="checkbox"/> Antidepressants, SSRI | <input type="checkbox"/> Pulmonary Arterial Hypertension |

18. Is the member new to ForwardHealth (i.e., has this member been granted eligibility for ForwardHealth within the past month)? Yes No

If yes, indicate the month and year the member became eligible in the space provided. _____ / _____
Month Year

19. Has the member taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response? Yes No

If yes, indicate the month and year the member began taking the drug in the space provided. _____ / _____
Month Year

20. Was the member recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested? Yes No

If yes, indicate the facility and month and year of discharge in the space provided.

Facility Name _____ / _____
Month Year

21. SIGNATURE — Prescriber

22. Date Signed

Continued

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)

24. Days' Supply Requested (Up to 365 Days)

25. NPI

26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

29. Grant Date

30. Expiration Date

31. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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