

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR
CYMBALTA FOR GENERALIZED ANXIETY DISORDER (GAD)**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) Completion Instructions, F-00283A. 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) for Step Therapy for Cymbalta for Generalized Anxiety Disorder (GAD) 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 or on paper. 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
Cymbalta

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Does the member have a diagnosis of GAD?

Yes

No

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PAROXETINE

15. Has the member previously taken paroxetine?

Yes

No

Continued



DT-PA098-098

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PAROXETINE (Continued)

16. Has the member taken any formulation of paroxetine for GAD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? Yes No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates paroxetine was taken in the space provided.

17. Is there a clinically significant drug interaction between another medication the member is taking and paroxetine? Yes No

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

18. Does the member have a medical condition(s) or contraindication(s) that prevents him or her from taking paroxetine? Yes No

If yes, list the medical condition(s) or contraindication(s) in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF VENLAFAXINE

19. Has the member taken any formulation of venlafaxine for GAD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? Yes No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates venlafaxine was taken in the space provided.

20. SIGNATURE — Prescriber

21. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

22. National Drug Code (11 Digits)

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

24. NPI

25. 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.)

26. Place of Service

27. Assigned PA Number

28. Grant Date

29. Expiration Date

30. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

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