

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR PROTON PUMP INHIBITOR (PPI) SUSPENSIONS AND ORALLY DISINTEGRATING
TABLETS**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets Completion Instructions, F-00433A. 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 Proton Pump Inhibitor (PPI) Suspensions and Orally Disintegrating Tablets 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

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

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED SUSPENSIONS

14. Does the member have a swallowing condition that prevents the member from swallowing a tablet or capsule?

Yes No

If yes, list the condition in the space provided.

Continued



DT-PA040-040

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED SUSPENSIONS (Continued)

15. Has the member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole? Yes No

If yes, list the approximate dates omeprazole was taken in the space provided.

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16. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of omeprazole? Yes No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates omeprazole was taken in the space provided.

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17. Has the member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole? Yes No

If yes, list the approximate dates pantoprazole was taken in the space provided.

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18. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of pantoprazole? Yes No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates pantoprazole was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED ORALLY DISINTEGRATING TABLETS

19. Does the member have a swallowing condition that prevents the member from swallowing a tablet or capsule? Yes No

If yes, list the condition in the space provided.

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20. Does the member have medical condition(s) that prevents the member from taking a PPI suspension? Yes No

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

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21. Is member preference the reason why the member is unable to take a PPI suspension? Yes No

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22. Has the member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole? Yes No

If yes, list the approximate dates omeprazole was taken in the space provided.

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23. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of omeprazole? Yes No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates omeprazole was taken in the space provided.

SECTION IIIB — CLINICAL INFORMATION FOR NON-PREFERRED ORALLY DISINTEGRATING TABLETS (Continued)

24. Has the member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole? Yes No

If yes, list the approximate dates pantoprazole was taken in the space provided.

25. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with any dosage form of pantoprazole? Yes No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates pantoprazole was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

26. SIGNATURE — Prescriber

27. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

28. National Drug Code (11 Digits)

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

30. NPI

31. 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.)

32. Place of Service

33. Assigned PA Number

34. Grant Date

35. Expiration Date

36. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

37. 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.
