

**FORWARDHEALTH  
PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA)**

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions, F-11049A.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — TYPE OF REQUEST**

4. Indicate the Start Date Requested / Date Prescription Filled

5. Indicate if this drug has been previously requested.

This is an initial PA request for this drug, for this member, by this provider.

This is a request to renew or extend previously prior authorized therapy using this drug.

First PA Number \_\_\_\_\_

This is a request to change or add a new National Drug Code (NDC) number to a current valid PA.

First PA Number \_\_\_\_\_ NDC Number to add \_\_\_\_\_

**SECTION III — PRESCRIPTION INFORMATION**

6. Drug Name	7. Strength
8. Quantity Ordered	9. Date Order Issued
10. Directions for Use	
11. Daily Dose	12. Refills
13. Name — Prescriber	14. National Provider Identifier
15. "Brand Medically Necessary" is handwritten by the prescriber on the prescription order. <input type="checkbox"/> Yes <input type="checkbox"/> No	

*Continued*



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**SECTION IV — CLINICAL INFORMATION**

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16. List the member's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for pharmaceutical care members. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

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17. Source for Clinical Information (check one)

- This information was primarily obtained from the prescriber or prescription order.
- This information was primarily obtained from the member.
- This information was primarily obtained from some other source (specify). \_\_\_\_\_

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18. Use (check one)

- Compendial standards, such as the United States Pharmacopeia Drug Information (USP DI) or drug package insert, lists the intended use identified above as an accepted indication.
- Compendial standards, such as the USP DI, lists the intended use identified above as a [bracketed] accepted indication.
- Compendial standards, such as the USP DI or drug package insert, lists the intended use identified above as an unaccepted indication.
- The intended use above is not listed in compendial standards. Peer reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.)

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19. Dose (check one)

- The daily dose and duration are within compendial standards general prescribing or dosing limits for the indicated use.
- The daily dose and duration are **not** within compendial standards general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

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20. **SIGNATURE** — Pharmacist or Dispensing Physician

21. Date Signed

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