

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 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. 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

12. Diagnosis Code and Description

13. Has the member experienced treatment failure with the preferred drug(s)? Yes No

If yes, list the most recently failed preferred drug(s), specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken.

14. Does the member have a medical condition(s) that prevents the use of the preferred drug(s)? Yes No

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

15. Is there a clinically significant drug interaction between another medication the member is taking and the preferred drug(s)? Yes No

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

16. Has the member experienced a clinically significant adverse drug reaction while taking the preferred drug(s)? Yes No

If yes, list the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken.

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SECTION III— CLINICAL INFORMATION (Continued)

17. For grandfathered classes, including, but not limited to, anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics, has the member taken the requested non-preferred medication for more than 30 days outside ForwardHealth and had a measurable, therapeutic response? Yes No

18. **SIGNATURE** — Prescriber

19. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 Digits)

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

22. NPI

23. 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.)

24. Place of Service

25. Assigned PA Number

26. Grant Date

27. Expiration Date

28. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

29. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a member who was granted retroactive eligibility by ForwardHealth.
