

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR STIMULANTS AND RELATED AGENTS**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, F-11097A. 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 Stimulants and Related Agents 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 FOR STIMULANTS AND RELATED AGENTS (Required for all requests.)

12. Diagnosis Code and Description

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Intuniv, Kapvay, and Strattera.)

13. Has the member experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants?

Yes No

If yes, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

List the drug names and doses, documentation regarding previous use, and approximate dates the preferred stimulants were taken below.

A.) _____

B.) _____

Continued



DT-PA041-041

SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA REQUESTS

14. Has the member experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants? Yes No

If yes, list the two preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

List the drug names and doses, documentation regarding previous use, and approximate dates the preferred stimulants were taken below.

A.) _____

B.) _____

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15. Does the member have a medical condition(s) (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant? Yes No

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

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16. Does the member have a medical history of substance abuse or misuse? Yes No

If yes, explain in the space provided.

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17. Does the member have a serious risk of drug diversion? Yes No

If yes, explain in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR INTUNIV AND KAPVAY REQUESTS

18. Will the member take Intuniv or Kapvay in combination with a preferred stimulant? Yes No

If yes, list the preferred stimulant in the space provided.

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19. Has the member experienced a treatment failure with a preferred stimulant? Yes No

If yes, list the preferred stimulant, specific details about the treatment failure, and the approximate date(s) the preferred stimulant was taken in the space provided.

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20. Does the member have a medical condition(s) preventing the use of a preferred stimulant? Yes No

If yes, list the medical condition(s) that prevents the use of a preferred stimulant in the space provided.

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21. Is there a clinically significant drug interaction between another medication the member is taking and a preferred stimulant? Yes No

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

SECTION III C — CLINICAL INFORMATION FOR INTUNIV AND KAPVAY REQUESTS (Continued)

22. Has the member experienced a clinically significant adverse drug reaction to a preferred stimulant? Yes No

If yes, list the name of the preferred stimulant, specific details about the clinically significant adverse drug reaction, and the approximate dates of the adverse drug reaction in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

23. SIGNATURE — Prescriber

24. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

25. National Drug Code (11 Digits)

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

27. NPI

28. 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.)

29. Place of Service

30. Assigned PA Number

31. Grant Date

32. Expiration Date

33. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

34. 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.
