

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR ELIDEL[®] AND PROTOPIC[®]**

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Elidel[®] and Protopic[®] Completion Instructions, F-11303A. 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 Elidel[®] and Protopic[®] 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. Is the member younger than 2 years of age?

Yes

No

If yes, the prescriber attests by signing below to having discussed the potential risks and warnings of prescribing Elidel[®] or Protopic[®] with the member's parent or guardian. Elidel[®] and Protopic[®] are not approved by the Food and Drug Administration for children younger than 2 years of age.

SIGNATURE — Prescriber

Date Signed

14. Is the prescription for Elidel[®] or Protopic[®] written by a dermatologist or an allergist or through a dermatology or allergy consultation?

Yes

No

15. Is the member immunocompromised?

Yes

No

16. Has the member taken an antiretroviral or antineoplastic agent within the past two years?

Yes

No

Continued



DT-PA071-071

SECTION III — CLINICAL INFORMATION (Continued)

17. Has the member experienced a treatment failure or a clinically significant adverse drug reaction to a topical corticosteroid in the past 183 days? Yes No

If yes, list the topical corticosteroid and the approximate dates taken in the space provided.

18. Has the member received treatment with Elidel® or Protopic® in the past 183 days and achieved a measurable therapeutic response? Yes No

SECTION IV — AUTHORIZED SIGNATURE

19. SIGNATURE — Prescriber

20. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 Digits)

22. Days' Supply Requested (Up to 183 Days)

23. NPI

24. 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.)

25. Place of Service

26. Assigned PA Number

27. Grant Date

28. Expiration Date

29. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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