

FORWARDHEALTH
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions, F-11306A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis 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 PLAQUE PSORIASIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of plaque psoriasis? Yes No

14. Does the member have moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area? Yes No

15. Does the member have a diagnosis of palmoplantar psoriasis? Yes No

16. Is the prescription written by a dermatologist or through a dermatology consultation? Yes No

Continued



DT-PA074-074

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS (Continued)

17. Has the member received **one** or more of the treatments listed below and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction? Yes No

If yes, check the box next to the treatment(s) the member received. Indicate the dose of the treatment(s), specific details about the unsatisfactory therapeutic response or clinically significant adverse reaction(s), and the approximate date(s) of the treatment(s) in the space provided.

- 1. cyclosporine _____
- 2. methotrexate _____
- 3. phototherapy _____
- 4. Soriatane _____

SECTION IIIA — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS

18. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction to a preferred cytokine and molecule (CAM) antagonist drug? Yes No

If yes, list the preferred cytokine and CAM antagonist drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

19. SIGNATURE — Prescriber	20. Date Signed
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SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 digits)	22. Days' Supply Requested (Up to 365 Days)
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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
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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.