

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA)  
AND POLYARTICULAR JUVENILE RA**

**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 Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA Completion Instructions, F-11308A. Providers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage](http://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 Rheumatoid Arthritis (RA) and Polyarticular Juvenile Rheumatoid Arthritis (RA) 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.

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**SECTION I — MEMBER INFORMATION**

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1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

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**SECTION II — PRESCRIPTION INFORMATION**

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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

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**SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE RA (Required for all requests.)**

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12. Diagnosis Code and Description

13. Does the member have a diagnosis of polyarticular juvenile rheumatoid arthritis?

Yes  No

14. Does the member have a diagnosis of rheumatoid arthritis?

Yes  No

15. Does the member have moderate to severe symptoms of rheumatoid arthritis?

Yes  No

16. Is the prescription written by a rheumatologist or through a rheumatology consultation?

Yes  No

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DT-PA076-076

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**SECTION III — CLINICAL INFORMATION FOR RA AND POLYARTICULAR JUVENILE RA (Continued)**

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

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space below.

- 1.  azathioprine \_\_\_\_\_
- 2.  corticosteroids \_\_\_\_\_
- 3.  cyclosporine \_\_\_\_\_
- 4.  hydroxychloroquine \_\_\_\_\_
- 5.  leflunomide \_\_\_\_\_
- 6.  methotrexate \_\_\_\_\_
- 7.  NSAIDs or COX-2 \_\_\_\_\_
- 8.  penicillamine \_\_\_\_\_
- 9.  sulfasalazine \_\_\_\_\_

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

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18. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to a preferred cytokine and 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 drug reaction, and the approximate dates the preferred cytokine and CAM antagonist drug was taken in the space provided.

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**SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS**

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19. Will the member continue to take methotrexate in combination with Simponi?  Yes  No

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**SECTION IV — AUTHORIZED SIGNATURE**

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20. SIGNATURE — Prescriber	21. Date Signed
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**SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA**

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22. National Drug Code (11 digits)	23. Days' Supply Requested (Up to 365 Days)
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24. NPI

25. 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.)

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**SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA (Continued)**

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26. Place of Service

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27. Assigned PA Number

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28. Grant Date

29. Expiration Date

30. Number of Days Approved

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**SECTION VI — ADDITIONAL INFORMATION**

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

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