**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-11078 (07/2022)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)**

**FOR PROTON PUMP INHIBITOR (PPI) CAPSULES, SUSPENSIONS, AND   
NON-ORALLY DISINTEGRATING TABLETS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules, Suspensions, and Non-Orally Disintegrating Tablets Instructions, F‑11078A. Prescribers may refer to the Forms page of the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms> for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules, Suspensions, and Non-Orally Disintegrating Tablets form signed and dated by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Prescribers and pharmacy providers may call Provider Services at 800‑947‑9627 with questions.

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| **SECTION I – MEMBER INFORMATION** | | |
| 1. Name – Member (Last, First, Middle Initial) | | |
| 2. Member ID Number | 3. Date of Birth – Member | |
| **SECTION II – PRESCRIPTION INFORMATION** | | |
| 4. Drug Name | 5. Drug Strength | |
| 6. Date Prescription Written | 7. Refills | |
| 8. Directions for Use | | |
| 9. Name –Prescriber | | |
| 10. Address –Prescriber (Street, City, State, Zip+4 Code) | | |
| 11. Phone Number – Prescriber | | 12. National Provider Identifier (NPI) – Prescriber |
| **SECTION III – CLINICAL INFORMATION (Required for All Requests)** | | |
| 13. Diagnosis Code and Description | | |

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| 14. Has the member experienced an unsatisfactory therapeutic response or a clinically  significant adverse drug reaction with **at least two** preferred PPI capsules,  suspensions, or non-orally disintegrating tablets?  Yes  No  If yes, list the drug name, dosage form, and dates the drug was taken in the space provided for **at least two** preferred PPI capsules, suspensions, or non-orally disintegrating tablets the member has taken.  Drug Name       Dosage Form       Dates Taken  Drug Name       Dosage Form       Dates Taken  Drug Name       Dosage Form       Dates Taken  Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) in the space provided. | | | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | | | |
| 15. **SIGNATURE** – Prescriber | | | 16. Date Signed | |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** | | | | |
| 17. National Drug Code (11 Digits) | | 18. Days’ Supply Requested (Up to 365 Days) | | |
| 19. NPI | | | | |
| 20. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.) | | | | |
| 21. Place of Service | | | | |
| 22. Assigned PA Number | | | | |
| 23. Grant Date | 24. Expiration Date | | | 25. Number of Days Approved |
| **SECTION VI – ADDITIONAL INFORMATION** | | | | |
| 26. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here. | | | | |