DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11078 (07/2022)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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.

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

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.

Reset Form