DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11083 (04/2017)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) Completion Instructions, F-11083A. 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/Brand Medically Necessary Attachment (PA/BMNA) form signed by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. 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 – Prescriber

10. Address – Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number – Prescriber

SECTION III – CLINICAL INFORMATION

12. Diagnosis – Primary Code and / or Description

As required in Wis. Admin. Code § DHS 107.10(3)(c), when a prescription is for a BMN drug, the prescriber is required to write "brand medically necessary" in his or her own handwriting. This required statement may be handwritten either directly on the prescription or on a separate order attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. Blanket authorization for an individual member, drug, or prescriber is not acceptable documentation.

13. Is “brand medically necessary” handwritten by the prescriber on the prescription or on a separate order attached to the original prescription? ☐ Yes ☐ No

Continued

DT-PA008-008

SECTION III – CLINICAL INFORMATION (Continued)

14. Has the member experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with at least two different manufacturers of the generic equivalent drug? ☐ Yes ☐ No

If yes, list the manufacturer or National Drug Code (NDC), dates taken, and indicate the specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) that can be directly attributed to the generic equivalent drugs.

Manufacturer / NDC Dates Taken

Indicate in the space provided the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction that can be directly attributed to this generic drug.

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Note: Pharmacy providers may provide manufacturer or NDC and dates taken.

15. Explain how the BMN drug will prevent the recurrence of the unsatisfactory therapeutic response or clinically significant adverse drug reaction described in Element 14.

16. Has the member taken the requested brand name drug for at least 30 consecutive days and had a measurable therapeutic response? ☐ Yes ☐ No

If yes, indicate the approximate dates the brand name drug was taken.

SECTION IV – AUTHORIZED SIGNATURE

17. **SIGNATURE** – Prescriber	18. Date Signed

SECTION V – ADDITIONAL INFORMATION

19. Additional diagnostic and clinical information explaining the need for the drug required may be included below.

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