DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00281 (07/2013)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR FENTANYL MUCOSAL AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions, F-00281A. Providers 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 Fentanyl Mucosal Agents 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, 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. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Does the member have cancer that is causing persistent pain? ❑ Yes ❑ No

15. Is the member tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain? ❑ Yes ❑ No

16. Is the member currently taking a long-acting opioid analgesic drug(s)? ❑ Yes ❑ No

If yes, list the long-acting opioid analgesic drug(s) and dose(s) the member is currently taking in the space provided.

Drug Name _____ Daily Dose _____

Drug Name _____ Daily Dose _____

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

17. Does the member experience breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drug(s)? ❑ Yes ❑ No

If yes, list the short-acting opioid analgesic drug(s) and dose(s) the member has previously taken in the space provided.

Drug Name _____ Daily Dose _____

Drug Name _____ Daily Dose _____

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 Digits)	21. Days' Supply Requested (Up to 183 Days)

22. NPI

23. 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.)

24. Place of Service

25. Assigned PA Number

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

29. 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