FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ULCERATIVE COLITIS

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 Ulcerative Colitis Instructions, F-00694A. 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/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis 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.

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 (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR ULCERATIVE COLITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of ulcerative colitis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of ulcerative colitis?	❑ Yes	❑ No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION FOR ULCERATIVE COLITIS (Continued)

16. 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 responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

1. ❑ oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine) _____
2. ❑ 6-mercaptopurine (6MP) _____
3. ❑ azathioprine _____
4. ❑ oral corticosteroids _____

17. Is the member currently using Humira® for ulcerative colitis? ❑ Yes ❑ No

If yes, complete Section IIIA of this form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING HUMIRA® FOR ULCERATIVE COLITIS

18. Has the member been using Humira® for ulcerative colitis for at least the past two months? ❑ Yes ❑ No

19. Has the member shown evidence of clinical remission since starting Humira®? ❑ Yes ❑ No

SECTION IV — AUTHORIZED SIGNATURE

20. **SIGNATURE** — Prescriber	21. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

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 or up to 14 days in the past.

26. Place of Service

27. Assigned PA Number

28. Grant Date	29. Expiration Date	30. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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.