DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00805 (03/15)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MULTIPLE SCLEROSIS (MS) AGENTS, IMMUNOMODULATORS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators Completion Instructions, F-00805A. 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 Multiple Sclerosis (MS) Agents, Immunomodulators form signed by the prescriber before 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 — 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. List the member's current MS immunomodulator therapy or check "none" if appropriate.

☐ None

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

Continued

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

15. List the member's previous MS immunomodulator therapy and reason(s) for discontinuation or check "none" if appropriate.

☐ None

Drug Name _____ Daily Dose _____ Dates Taken _____

Reason for Discontinuation _____

Drug Name _____ Daily Dose _____ Dates Taken _____

Reason for Discontinuation _____

Drug Name _____ Daily Dose _____ Dates Taken _____

Reason for Discontinuation _____

SECTION IV — CLINICAL INFORMATION FOR NON-PREFERRED ORAL MS IMMUNOMODULATORS

16. Prior authorization requests must include detailed documentation regarding why the member is unable to take or has previously discontinued Copaxone® treatment *and* MS interferon treatment. Medical records must be provided to support the need for a non-preferred oral agent. The following will *not* be considered as criteria to support the need for a non-preferred oral agent:
    - Non-adherence to previous MS treatment.
    - The member's fear of needles.
    - Member or prescriber preference for the use of an oral agent.

Copaxone® Documentation

MS Interferon Documentation

Continued

SECTION V — CLINICAL INFORMATION FOR COPAXONE® 40 MG

17. Prior authorization requests for Copaxone® 40 mg must include detailed documentation regarding why the member is unable to take or has previously discontinued Copaxone® 20 mg treatment. Medical records must be provided to support the need for Copaxone® 40 mg. The following will *not* be considered as criteria to support the need for Copaxone® 40 mg:
    - Non-adherence to previous MS treatment.
    - Member or prescriber preference for the use of Copaxone® 40 mg.

SECTION VI — AUTHORIZED SIGNATURE

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

SECTION VII — ADDITIONAL INFORMATION

20. 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