

**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 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. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the following preferred MS interferons:
Avonex, Betaseron, or Rebif?

Yes No

If yes, list the preferred MS interferon(s) used. _____

List the dates the preferred MS interferon(s) were taken. _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Continued



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

15. Is there a clinically significant drug interaction between another drug the member is taking and at least one of the following preferred MS interferons: Avonex, Betaseron, or Rebif? Yes No

If yes, list the drug(s) and interaction(s) in the space provided.

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16. Does the member have a medical condition(s) that prevents the use of at least one of the preferred MS interferons: Avonex, Betaseron, or Rebif? Yes No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred MS interferons in the space provided.

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17. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Copaxone? Yes No

If yes, list the dates Copaxone was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

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18. Is there a clinically significant drug interaction between another drug the member is taking and Copaxone? Yes No

If yes, list the drug(s) and interaction(s) in the space provided.

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19. Does the member have a medical condition(s) that prevents the use of Copaxone? Yes No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using Copaxone in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

20. SIGNATURE — Prescriber

21. Date Signed

Continued

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

22. National Drug Code (11 Digits)	23. Days' Supply Requested (Up to 365 Days)
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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 and / 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
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SECTION VI — ADDITIONAL INFORMATION

31. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.
