FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ANTICOAGULANTS, ORAL

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Anticoagulants, Oral Completion Instructions, F-00806A. 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 Anticoagulants, Oral 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 Pradaxa®? ❑ Yes ❑ No

If yes, list the dates Pradaxa® was taken. _____

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

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 Pradaxa®? ❑ Yes ❑ No

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

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Xarelto®? ❑ Yes ❑ No

    If yes, list the dates Xarelto® was taken. _____

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

17. Is there a clinically significant drug interaction between another drug the member is taking and Xarelto®? ❑ Yes ❑ No

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

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 365 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.

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