

**FORWARDHEALTH  
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR STRIBILD®**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Stribild® Completion Instructions, F-01249A. Providers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage](http://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 Drug Attachment for Stribild® form signed by the prescriber before submitting a prior authorization (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. Date Prescription Written

5. Directions for Use

6. Refills

7. Name — Prescriber

8. National Provider Identifier — Prescriber

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

10. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

11. Diagnosis Code and Description

12. List the member's current antiretroviral therapy (ART) or check "none" if appropriate.

None

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Start Date \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Start Date \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Start Date \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Start Date \_\_\_\_\_

13. List the member's previous ART or check "none" if appropriate.

None

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

*Continued*



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**SECTION III — CLINICAL INFORMATION (Continued)**

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14. List all non-ART drugs the member is currently receiving or check "none" if appropriate.

None

Drug Name _____	Drug Name _____	Drug Name _____
Drug Name _____	Drug Name _____	Drug Name _____
Drug Name _____	Drug Name _____	Drug Name _____
Drug Name _____	Drug Name _____	Drug Name _____

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15. Indicate the member's creatinine clearance (CrCl) and date taken.

CrCl \_\_\_\_\_ mL / minute    Test Date \_\_\_\_\_

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16. Indicate the member's Human Immunodeficiency Virus viral load and date taken.

Viral Load \_\_\_\_\_ copies / mL    Test Date \_\_\_\_\_

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**SECTION IV — AUTHORIZED SIGNATURE**

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17. SIGNATURE — Prescriber

18. Date Signed

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**SECTION V — ADDITIONAL INFORMATION**

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

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