**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-00081 (07/2024)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR OPIOID DEPENDENCY AGENTS – BUPRENORPHINE**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents–Buprenorphine Instructions, F-00081A. Prescribers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/
ForwardHealthCommunications.aspx?panel=Forms](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms)for the completion instructions.

Pharmacy providers are required to have a completed PA/PDL for Opioid Dependency Agents–Buprenorphine form signed and dated 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. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

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| **SECTION I – MEMBER INFORMATION** |
| 1. Name – Member (Last, First, Middle Initial)      |
| 2. Member ID 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. Address – Prescriber (Street, City, State, Zip+4 Code)      |
| 11. Phone Number – Prescriber      | 12. National Provider Identifier (NPI) – Prescriber      |
| **SECTION III – CLINICAL INFORMATION (Required for All PA Requests)** |
| 13. Diagnosis Code and Description      |
| 14. Is the member 16 years of age or older? [ ]  Yes [ ]  No |
| 15. Is the member taking any other opioids, tramadol, or carisoprodol? [ ]  Yes [ ]  NoIf yes, list the drugs taken and the dates they have been taken in the space provided.      |
| 16. Is the member pregnant? [ ]  Yes [ ]  NoIf yes, indicate the member’s expected delivery date (mm/dd/ccyy).       /       /       |
| **SECTION IV – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED BUPRENORPHINE-NALOXONE DRUG REQUESTS (PA requests for non-preferred buprenorphine-naloxone drugs may not be submitted via STAT-PA.)** |
| 17. Provide detailed clinical justification for prescribing a non-preferred buprenorphine-naloxone drug instead of buprenorphine-naloxone tablets, Suboxone film, and Zubsolv. Include clinical information why the member cannot use buprenorphine-naloxone tablets, Suboxone film, and Zubsolv and why it is medically necessary that the member receive a non-preferred buprenorphine-naloxone drug instead of buprenorphine-naloxone tablets, Suboxone film, and Zubsolv.      |
| **SECTION V – AUTHORIZED SIGNATURE** |
| 18. **SIGNATURE** – Prescriber | 19. Date Signed |
| **SECTION VI – FOR PHARMACY PROVIDERS USING STAT-PA** |
| 20. National Drug Code (11 Digits)      | 21. Days’ Supply Requested (Up to 183 Days)      |
| 22. NPI      |
| 23. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future 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      |

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| **SECTION VII – 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.      |