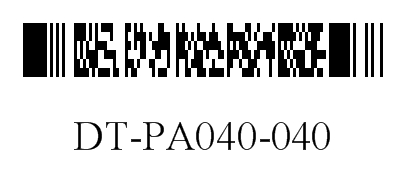
**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**



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

F-00433 (07/2022)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)**

**FOR PROTON PUMP INHIBITOR (PPI) ORALLY DISINTEGRATING TABLETS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets Instructions, F-00433A. Prescribers may refer to the Forms page of the ForwardHealth Portal at [https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ ForwardHealthCommunications.aspx?panel=Forms](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/%20ForwardHealthCommunications.aspx?panel=Forms) for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets 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 Requests)** | | | | | |
| 13. Diagnosis Code and Description | | | | | |
| 14. Is the member 5 years of age or older?  Yes  No | | | | | |
| 15. Does the member have a medical condition(s) that prevents the use  of PPI capsules and non-orally disintegrating tablets?  Yes  No  If yes, list the medical condition(s) and describe how it prevents the member from using PPI capsules and non-orally disintegrating tablets. | | | | | |
| 16. Has the member experienced an unsatisfactory therapeutic response or a clinically  significant adverse drug reaction with Nexium DR packet?  Yes  No  If yes, list the dates Nexium DR packet 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 Nexium DR packet?  Yes  No  If yes, list the drug(s) and interaction(s) in the space provided. | | | | | |
| 18. Has the member experienced an unsatisfactory therapeutic response or a clinically  significant adverse drug reaction with Protonix suspension? Yes  No  If yes, list the dates Protonix suspension was taken.  Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. | | | | | |
| 19. Is there a clinically significant drug interaction between another drug the member is  taking and Protonix suspension? Yes  No  If yes, list the drug(s) and interaction(s) in the space provided. | | | | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | | | | |
| 20. **SIGNATURE** – Prescriber | | | | | 21. Date Signed |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** | | | | | |
| 22. National Drug Code (11 Digits) | | | | 23. Days’ Supply Requested (Up to 365 Days) | |
| 24. NPI | | | | | |

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| --- | --- | --- |
| 25. Date of Service (DOS) (mmd/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.) | | |
| 26. Place of Service | | |
| 27. Assigned PA Number | | |
| 28. Grant Date | 29. Expiration Date | 30. Number of Days Approved |
| **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. | | |