DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00805 (07/2022)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MULTIPLE SCLEROSIS (MS) AGENTS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Multiple Sclerosis (MS) Agents Instructions, F-00805A. Prescribers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Multiple Sclerosis (MS) Agents form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

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 – Prescriber

SECTION III – CLINICAL INFORMATION (Required for All Requests)

13. Diagnosis Code and Description

Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.

DT-PA108-108

14. Is the member currently using the requested non-preferred MS agent? ☐ Yes ☐ No

If yes, indicate the approximate date the therapy was started.

SECTION IV – CLINICAL INFORMATION FOR NON-PREFERRED ORAL AGENTS AND KESIMPTA

15. Indicate the preferred oral MS agents the member has taken and provide specific details regarding the member's response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section VIII of this form.

Drug Name_____ Dose_____ Dates Taken_____

Description of Treatment Response and Reason(s) for Discontinuation

Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuation

Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuation

16. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred oral agent or Kesimpta.

SECTION V – CLINICAL INFORMATION FOR NON-PREFERRED INTERFERONS

17. Indicate the preferred MS interferons the member has taken and provide specific details regarding the member's response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section VIII of this form.

Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuation

Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuation

Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuation

18. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred interferon.

SECTION VI – CLINICAL INFORMATION FOR GLATOPA

19. PA requests for Glatopa must include detailed clinical justification for prescribing Glatopa instead of the preferred MS agents Copaxone 20 mg and Copaxone 40 mg. This clinical information must document why the member cannot use Copaxone 20 mg and Copaxone 40 mg, including why it is medically necessary that the member receive Glatopa instead of Copaxone 20 mg and Copaxone 40 mg.

SECTION VII – AUTHORIZED SIGNATURE

20. **SIGNATURE** – Prescriber	21. Date Signed

SECTION VIII – ADDITIONAL INFORMATION

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

Reset Form