FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR AMPHETAMINE FORMULATIONS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Amphetamine Formulations Completion Instructions, F-01672A. 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 Amphetamine Formulations 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. Directions for Use

8. Name — Prescriber

9. National Provider Identifier (NPI) — Prescriber

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

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

12. Diagnosis Code and Description

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

If yes, list the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates that Vyvanse® was taken in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

14. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred stimulant, other than Vyvanse®? ☐ Yes ☐ No

If yes, list the preferred stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred stimulant was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

15. **SIGNATURE** — Prescriber	16. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)	18. Days' Supply Requested (Up to 365 Days)

19. NPI

20. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.)

21. Place of Service

22. Assigned PA Number

23. Grant Date	24. Expiration Date	25. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

26. 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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