**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Health Care Access and Accountability Wis. Admin. Code § DHS 107.10(2)

F-01672 (01/2017)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR NON-PREFERRED STIMULANTS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Preferred Stimulants 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*](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/Preferred Drug List (PA/PDL) for Non-Preferred Stimulants 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.

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| **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 taken Vyvanse® for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response? [ ]  Yes [ ]  NoIf yes, list the dose, dosage adjustments, specific details about the unsatisfactory therapeutic response, and the approximate dates that Vyvanse® was taken in the space provided.      |

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| **SECTION III – CLINICAL INFORMATION (Continued)** |
| 14. Has the member taken Vyvanse® and experienced a clinically significant adverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the dose, specific details about the significant adverse drug reaction, and the approximate dates that Vyvanse® was taken in the space provided.       |
| 15. Has the member taken a methylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response? [ ]  Yes [ ]  NoIf yes, list the methylphenidate stimulant, dose, dosage adjustments, specific details about the unsatisfactory therapeutic response, and the approximate dates that the methylphenidate stimulant was taken in the space provided.       |
| 16. Has the member taken a methylphenidate stimulant and experienced a clinicallysignificant adverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the methylphenidate stimulant, dose, specific details about the significant adverse drug reaction, and the approximate dates that the methylphenidate stimulant was taken in the space provided.       |
| 17. Has the member taken a dexmethylphenidate stimulant for at least 60 consecutivedays with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response? [ ]  Yes [ ]  NoIf yes, list the dexmethylphenidate stimulant, dose, dosage adjustments, specific details about the unsatisfactory therapeutic response, and the approximate dates that the dexmethylphenidate stimulant was taken in the space provided.      |
| 18. Has the member taken a dexmethylphenidate stimulant and experienced a clinically significant adverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the dexmethylphenidate stimulant, dose, specific details about the significant adverse drug reaction, and the approximate dates that the dexmethylphenidate stimulant was taken in the space provided.       |

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| **SECTION IV – AUTHORIZED SIGNATURE** |
| 19. **SIGNATURE** – Prescriber | 20. Date Signed      |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** |
| 21. National Drug Code (11 Digits)      | 22. Days’ Supply Requested (Up to 365 Days)      |
| 23. NPI      |
| 24. 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.)      |
| 25. Place of Service      |
| 26. Assigned PA Number      |
| 27. Grant Date      | 28. Expiration Date      | 29. Number of Days Approved      |
| **SECTION VI – ADDITIONAL INFORMATION** |
| 30. 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.       |