**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-01673 (04/2022)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)   
FOR OREXIN RECEPTOR ANTAGONISTS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Orexin Receptor AntagonistsInstructions, F‑01673A. 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/ForwardHealthCommunications.aspx?panel=Forms) for the completion instructions.

Pharmacy providers are required to have a completed PA/PDL for Orexin Receptor Antagonistsform 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. Directions for Use | |
| 8. Refills | | |
| 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** | | |
| 13. Diagnosis Code and Description | | |
| 14. Is the member’s age consistent with Food and Drug Administration-approved  product labeling for the requested drug?  Yes  No | | |
| 15. Does the member have narcolepsy?  Yes  No | | |

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| 16. Does the member have a medical history of substance abuse or misuse?  Yes  No | | | | |
| 17. Has the member experienced an unsatisfactory therapeutic response or a clinically  significant adverse drug reaction with **at least two** preferred drugs from the sedative hypnotics drug class?  Yes  No  If yes, list the drug names and the dates they were taken in the space provided.  Drug Name       Dates Taken  Drug Name       Dates Taken  Drug Name       Dates Taken  Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s). | | | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | | | |
| 18. **SIGNATURE** – Prescribing Provider | | | | 19. Date Signed |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** | | | | |
| 20. National Drug Code (11 Digits) | | 21. Days’ Supply Requested (Up to 365 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 | |
| **SECTION VI – 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. | | | | |