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 Antagonists Instructions, 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 for the completion instructions.

Pharmacy providers are required to have a completed PA/PDL for Orexin Receptor Antagonists 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.

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.

Reset Form