**FORWARDHEALTH**

# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR BELSOMRA AND DAYVIGO

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Belsomra and Dayvigo Instructions, F-01673A. Providers 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/Preferred Drug List (PA/PDL) for Belsomra and Dayvigo 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 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. National Provider Identifier – Prescriber |
|---|---|

11. Address – Prescriber (Street, City, State, Zip+4 Code)

12. Phone Number – Prescriber

## SECTION III – CLINICAL INFORMATION

13. Diagnosis Code and Description

| | | |
|---|---|---|
| 14. Is the member 18 years of age or older? | ☐ Yes | ☐ No |
| 15. Does the member have narcolepsy? | ☐ Yes | ☐ No |
| 16. Does the member have a medical history of substance abuse or misuse? | ☐ Yes | ☐ No |

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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 name and date(s) the drug was taken in the space provided for **at least two** preferred drugs the member has taken from the sedative hypnotics drug class.

Drug Name _____ Date(s) Taken _____

Drug Name _____ Date(s) Taken _____

Drug Name _____ Date(s) 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. National Provider Identifier

23. 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.)

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