

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR BELSOMRA®**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Belsomra® Completion Instructions, F-01673A. 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 Belsomra® 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. Refills

9. Name — Prescriber

10. National Provider Identifier — Prescriber

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

12. Telephone 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

*Continued*



DT-PA114-114

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**SECTION III — CLINICAL INFORMATION (Continued)**

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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 dates 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 \_\_\_\_\_ Dates Taken \_\_\_\_\_

Drug Name \_\_\_\_\_ Dates Taken \_\_\_\_\_

Drug Name \_\_\_\_\_ Dates Taken \_\_\_\_\_

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

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**SECTION IV — AUTHORIZED SIGNATURE**

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18. SIGNATURE — Prescribing Provider

19. Date Signed

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**SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA**

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20. National Drug Code (11 Digits)

21. Days' Supply Requested (Up to 365 Days)

22. NPI

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

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**SECTION VI — ADDITIONAL INFORMATION**

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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.

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