FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR HIDRADENITIS SUPPURATIVA

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa Completion Instructions, F-01674A. Providers may refer to the Forms page of the ForwardHealth Portal at *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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a prior authorization (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. 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 FOR HIDRADENITIS SUPPURATIVA

12. Diagnosis Code and Description

13. Does the member have a diagnosis of hidradenitis suppurativa?	❑ Yes	❑ No
14. Is the prescription written by a dermatologist or through a dermatology consultation?	❑ Yes	❑ No
15. Does the member have recurrent abscesses with sinus tracts and scarring?	❑ Yes	❑ No
16. Has the member had laser therapy, excision, or deroofing surgery to treat hidradenitis suppurativa?	❑ Yes	❑ No
17. Has the member received **one** or more of the drug therapies listed below and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction?	❑ Yes	❑ No

If yes, check the box next to the drug therapy the member received. Indicate the drug(s) taken, dose(s), approximate date(s) the drug(s) was taken, and specific details about the unsatisfactory therapeutic response(s) or clinically significant adverse reaction(s) in the space provided.

1. ☐ Antibiotics _____
2. ☐ Retinoids _____
3. ☐ Other _____

Continued

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	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 (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 product requested may be included here.

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